DOCUMENT RESUME

ED 345 141 CG 024 208

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TITLE Child Sexual Abuse in America--A Call for School & Community Action. A Report of a National Study.
INSTITUTION Western Washington Univ., Bellingham. National Rural Development Inst.
PUB DATE Mar 92
NOTE 73p.
PUB TYPE Reports - Research/Technical (143)

EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS Elementary School Students; Elementary Secondary Education; National Surveys; Prevention; Program Design; Program Evaluation; School Activities; *School Counseling; Secondary School Students; *Sexual Abuse; Staff Development

ABSTRACT

The rate of sexual abuse of children and adults in our society is appalling, and growing rapidly. This study was designed to determine trends in child sexual abuse prevention and treatment services offered by school districts across America. The questionnaire was designed to allow comparisons of urban, rural, and suburban school district programs (N=211), and to determine gaps in services. In spite of the fact that one in three girls and one in four or five boys are sexually abused by age 18, 51.7 percent of the surveyed districts did not have prevention and treatment programs. Findings indicated that the districts tend to tell staff to report abuse, but do not adequately train them regarding how to prevent and treat child sexual abuse. Follow-up tends to be highly inadequate, as does support for students. Sexual abuse prevention and treatment programs typically were offered in only one grade. Many school planning committees have assumed that teaching children to "just say no" to sexual abuse would solve the problem. Results regarding inservice topics were consistent with more conventional roles of schools to meet legal requirements versus directly addressing social issues. One-fourth of the respondents reported that their district had "no procedures" for supporting staff who had difficulty with sexual abuse issues. Program evaluation did not appear to be a priority of district programs. (LLL)

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A Report of a National Study

March 1992

Doris Helge, Ph.D.

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EXECUTIVE SUMMARY

This executive summary reports on the results of a national study designed to determine trends in child sexual abuse prevention and treatment services, offered by school districts across America. A total of 211 rural, urban, and suburban district respondents were interviewed. In addition, all states' administrative regulations regarding child abuse and neglect were reviewed.

Extent of Child Sexual Abuse

Although accurate statistics regarding child sexual abuse are difficult to obtain, the rate of sexual abuse in our society is appalling, and growing rapidly. Several national organizations and studies have estimated that one in three girls and one in four or five boys experience sexual abuse by the age of 18 years. Sexual abuse occurs in all racial, ethnic, class, geographic, and cultural groups.

Our society is beginning to be aware of, and to accept ownership for, child abuse. Yet, children in America are not sufficiently protected by state or federal laws and regulations. Some of the primary professions that could and should be most aligned with children's rights have been slow to respond. These include the medical profession and the field of education.

America's Children are Not Protected

All states, as per Public Law 93-247 (P.L. 93-247), the Child Abuse Prevention and Treatment Act, must have in effect a state child abuse and neglect law providing for the reporting of abuse and neglect, and for other provisions such as follow-up investigations, if states are to be eligible to receive funding for projects under P.L. 93-247. Thus, state regulations determine how well children are protected, and state "mandates" vary tremendously. For example, most states merely "encourage" school districts to train their personnel regarding child abuse identification and reporting techniques. Only three states require that teachers receive such training in order to receive teacher certification.

Penalties for not reporting child abuse vary from as low as $0 up to $5,000 and/or a 90-day imprisonment. The focus in state administrative codes appears to be on reporting, versus on training personnel, so that children can receive appropriate follow-through services. (One notable exception is one state's regulations stating that schools are the best place to deal with child sexual abuse, because it usually occurs in the child's home). Yet, the majority of the state's regulations are mired in language which undermines enforcement, while "encouraging" (versus mandating) teacher training or community education. Most state incest laws are problematic by definition, by requirements to prove occurrence, and/or because they are coupled with meager punishment for offenders.

A number of problems were reported by study respondents regarding enforcement of state "mandates." Respondents in this study reported that local law enforcement and child protective services agencies frequently do not follow-up regarding reports of abuse. It was reported that many school personnel do not believe children when they report abuse. Teachers are frequently "reporting" abuse to persons other than legal authorities, and sometimes these individuals chose to "handle the situation informally."

As a society, we must take a look at our state regulations, our laws concerning incest, and related teacher training and teacher certification requirements. We also must better screen and train foster care parents, as many children are re-abused while in foster care. We must also better enforce existing laws and regulations.

Child Sexual Abuse as a Major Social Problem

The media are beginning to be more factual in presentations regarding child sexual abuse and to more frequently advocate that stronger actions be taken to protect children. Yet, social and gender inequality and cultural support of violence are still promulgated by the media and by other aspects of our society.

Child sexual abuse is not about sexual intimacy. It is about the exercise of power and control. Sexual abuse is a crime of violence.

Child sexual abuse is related to America's major social problems. These include drug and alcohol abuse, domestic violence, runaway children, gangs, mental illness, crime, dysfunctional families, HIV and other sexually transmitted diseases, teen pregnancy, prostitution, school dropouts, low self-esteem, homelessness, sexual dysfunction, eating disorders, violence, pornography, and the high rate of divorce.

Children as P.O.W.'s

This survey revealed a great deal of denial in America about the extent and effects of child sexual abuse. In eighty percent of all child sexual abuse, the offender is known to the child. Children are most frequently victimized by their caretakers, usually a family member. Child sexual abuse causes a post-traumatic stress in which those victimized experience the same reactions as do prisoners of war. The ongoing problem that results is a fixed set of learned behaviors (e.g., accepting the role of victim, inability to stand up for one's self, feelings of helplessness, and inability to flee from terror). Sexual abuse vastly effects a child's self-esteem. Typically, children who have been victimized must work for many years to heal issues ranging from fears of abandonment, terror, rage, and all areas of self-image. For example, most children struggle through adolescence and many through adulthood, with their rights to set and maintain sexual, emotional, physical, and other boundaries: state what they do and do not want; trust; and to experience healthy, intimate relationships. Many also repetitively struggle with continued emotional, sexual, or physical abuse. Suicide attempts, drug and alcohol abuse, eating disorders, and/or repeated revictimization are common.

The medical model is not appropriate in dealing with child sexual abuse. "Symptoms" are not "mental illness" or "emotional disturbances" but learned behaviors of survival. They are highly adaptive survival mechanisms.

While some local district programs are quite effective, the majority appear to be focusing on meeting legal requirements concerning reporting child abuse and avoiding potential lawsuits. Most district programs are not meeting the needs of children who already have been deprived of their basic rights to be safe, receive love, and be given opportunities to develop to their full potential.

Current School District Responses

In spite of the fact that one in three girls and one in four or five boys are sexually abused by age eighteen, the majority (51.7 percent) of the random sampling of school districts reported that they did not have child sexual abuse prevention and treatment programs. Generally, in the 48.3 percent of the districts that reported having programs, staff were at least told to report abuse, but were not adequately trained regarding how to prevent abuse and how to assist students who were identified as having been abused.

Even though stopping child abuse requires the involvement of the entire community, citizens of the community were seldom involved in training activities. The target population regarding preventing child sexual abuse (students) were only reported as receiving training by 43.8 percent of urban, 54.2 percent rural, and 63.7 percent of the suburban districts that reported having sexual abuse prevention and treatment programs (48.3 percent of the total sample). Almost half of the rural and suburban district respondents reported that their staff who were designated to deal with child sexual abuse were only "moderately comfortable" discussing child sexual abuse.

Programs conducted with students emphasized refusal skills. Reportedly, most programs appeared, at most, to offer one assembly per year in some grades, encouraging children to "say no" to sexual abuse. As child sexual abuse is about power being exerted over a dependent child, it is unrealistic to think that children are empowered by a once a year assembly, in certain grades, to "say no." Dependent children do not have the physical prowess to be able to say no and walk away. Research has indicated that most perpetrators confuse and threaten children and that children are also shamed into keeping the secret of sexual abuse. Sexually abused children must receive ongoing, consistent support from adults whom they can trust, before they are able to report abuse, much less refuse future abuse. Children must be assured that the abuse was not their fault.

Generally, districts seem to lack an understanding that identification of students who have been abused is only the first of many steps involved in the child's healing. While some districts had quality follow-up programs and services, follow-up services appeared to be inadequate in the great majority of school districts.

School personnel across the U.S. must become aware that legal requirements to identify and report sexual abuse is only the first step in a healing process.

School programs should be developmentally appropriate, with follow-up activities for identified children, appropriate for their stages of healing. Prevention and identification activities should start at preschool ages and should be integrated into ongoing school activities. Immediate intervention must occur when abuse is identified. District and community personnel also need to be made aware of national studies clearly indicating that children do not report abuse if it does not occur. Children will not inflict the feelings of shame related to sexual abuse, upon themselves, without a reason. On the contrary, studies have indicated that it is human nature to repress and deny abuse as long as possible because of the shame and other stress it produces and because of the threats that have been made against the child who has been abused.

Districts with successful programs reported that the strategies they found most effective included community awareness and prevention activities. These included identifying families at-risk and working to empower them so that they do not need to abuse children to express their needs for power. Effective strategies also included active and confidential interagency collaboration and case management teams regarding specific children who had been identified. Recommended strategies also included support groups, methods to develop student self-esteem, and the use of expressive therapies to assist students in expressing and validating their feelings and enhancing their self-esteem.

Teacher Education Needs

As our society is just now beginning to take a serious look at child sexual abuse, and 94 percent (47) of the states have no minimal teacher certification requirements regarding training in child sexual abuse, most educators have not been trained to deal with children who have been abused. Most teachers are quite concerned with how to fulfill their responsibilities to the children who have been abused and still teach the larger classroom. Teachers need to be given opportunities to become comfortable with sexual abuse issues and need to be

trained regarding what to expect regarding children's progress as they move through developmental stages of healing. Teachers need specific suggestions for use in classroom settings so that a child receives support yet is not ostracized.

Sexual abuse of children has numerous ramifications for the classroom teacher. These include dealing with depression, low self-esteem, teen pregnancies, juvenile delinquency, "acting out" behavior, and eating disorders. Learning to work with students who have been sexually abused will enhance teachers' abilities to work with all children. Thus, teacher training needs to go far beyond how to observe children for sexual abuse symptoms and how to report abuse to legal authorities.

School personnel need to understand that most abused children tend to cope well in areas that ensure their survival. Some children, thus, may appear to be well adjusted, happy children and may be "people pleasers," yet may be "ticking time bombs" full of unexpressed rage and low self-esteem. It is essential that children be heard, have their feelings validated, and become empowered. This can occur in a variety of ways, and it does take time.

From Denial to Action

The entire community must own the problem, become aware of its seriousness, and how widespread it is, and collaboratively design comprehensive solutions. Non-judgmental identification and services for families at-risk should be in existence. Public service announcements and other techniques should be used in a high profile manner. These should clarify that child sexual abuse will not be tolerated and that offenders will be prosecuted. They should state that child sexual abuse has profound effects on individual children and on the community, in terms of the social problems with which it is associated.

Social action is essential, and must be comprehensive, thoughtful, and ongoing. Child sexual abuse, and related problems, have evolved over centuries, and they will not disappear overnight. Sexual abuse is typically a cyclical, generational family phenomenon. Perpetrators usually victimize numbers of children repetitively. They must be legally stopped. Our future generation is at stake.

Children who are being abused need to be heard, made safe, have their feelings validated, and become empowered. We must empower and support teachers so that they can empower and empathize with students. We must empower families who are at-risk, so that their needs are met, and abuse does not occur.

Just as, during the 1980's, schools across the U.S. were compelled to enter the arena of drug and alcohol abuse education, during the 1990's, schools are more frequently being required to intervene in another area previously assumed to be a "family affair" - child sexual abuse.

Children who are in pain do not learn effectively and cannot fulfill their potential for themselves or for our society. Children who have been abused contain unexpressed rage in their bodies. This rage will eventually be expressed. It may be turned inward (e.g., suicide, self-mutilation, anorexia-bulimia). It may be expressed violently (crime, becoming a perpetrator). The effects of abuse may be expressed through drug and alcohol abuse or teen pregnancy. Any of these effects have implications for America's classrooms. Thus, we have no choice but to make schools' roles in the prevention and treatment of child sexual abuse a priority.

If our schools and the larger society handle our current child sexual abuse problems effectively, the next generation of students will be healthier and will produce more loving families, with children who are able to learn and to become productive citizens. If not, we will produce another generation of perpetrators and of social problems related to sexual abuse. Our next generation will thus be composed of adolescents and adults poorly equipped to be parents and productive citizens.

<u>For Further Information</u>

For further information regarding effective curriculum for children who have experienced abuse, contact: Dr. Doris Helge, Director, National Rural Development Institute, Western Washington University, Miller Hall 359, Bellingham, WA 98225, (206) 676-3576.

CHILD SEXUAL ABUSE PREVENTION AND TREATMENT SERVICES OFFERED BY U.S. SCHOOL DISTRICTS

INTRODUCTION

This national study was designed to determine trends in child sexual abuse prevention and treatment services, offered by school districts across America. The questionnaire and data analysis were designed to allow comparisons of rural, urban, and suburban school district programs and to determine gaps in services.

OPERATIONAL DEFINITIONS

Child sexual abuse or molestation is the misuse of power by an older, larger, or stronger person over a smaller or more vulnerable person through the use of forced or tricked sexualized touch, language, or behavior. Child sexual abuse also occurs when a child is used as an object for the sexual gratification of an adult or other older, more powerful person, through manipulation, exploitation, threats, or physical force. The older, more powerful person may be a minor under 18 years old, if that person is temporarily taking on the parental role (e.g., a baby-sitter).

Sexual abuse is not about sexual intimacy. It is about the exercise of power and control. It is about the physical violation of one's body through sexual contact or stimulation, or the violation of one's personal or psychological boundary through intrusive sexual contact (Nice and Forrest, 1990).

Incest is sexual abuse that occurs within a family. Due to tremendous changes in the last decades in American society, family may include step-parents, foster parents, a live-in boyfriend or girlfriend, uncle/aunt, or anyone who has a close family-like relationship with the victim (Lewis and Rosenfeld, 1991).

"Victim" is a word frequently used to indicate that a person is currently in an abusive situation. It may also be used to reflect a particular stage of the healing process, indicating how an individual feels in relationship to the abuse.

"Survivor" (versus "victim") is a word that has been introduced by those who have experienced sexual abuse and want to acknowledge their strength and courage in surviving. This term will henceforth be used in this document, in recognition of the tremendous strength and courage required to survive, and to cope, in everyday society. For many survivors, the recognition of their experience as one of survival is the beginning of their healing process.

Inappropriate sexual contact with a child may include nonviolent abuse such as fondling, caressing, indecent exposure, or showing pornographic pictures to a child. It may also be violent, as in incestuous intercourse, rape, or sodomy. The child may be a willing or unwilling partner. In 80 percent of all cases of sexual abuse, the offender is known to the child (National Committee for the Prevention of Child

Abuse 1992; Finney, 1992; American Humane Association, 1988; Hart-Rossi, 1984; Lewis and Rosenfeld, 1991). Children who are victimized are most frequently victimized by their caretakers, usually family members (Lewis and Rosenfeld, 1991; American Humane Association, 1988; Hart-Rossi, 1984).

Rural, urban, and suburban districts were defined as follows in this study:

- *rural: number of inhabitants fewer than 150 per square mile, or located in a county where 60 percent or more of the population lives in communities of 5,000 or fewer.
- *urban: towns or cities of more than 250,000 population.
- *suburban: residential communities generally located outside the city limits, but dependent upon the central city.

METHODOLOGY

The study was initiated during the summer of 1991 and completed during the winter of 1992. The questionnaire (see Appendix A) was field tested and revised, as necessary. A total of 509 districts were randomly selected from all districts in the United States (over 15,000). The actual random sample consisted of 499 distinct districts, as ten duplicate pairs were located and discarded after the selection process was completed. Interviewers asked to speak to the person designated as in charge of at-risk student programs in the school district. Depending on the organizational structure of the district, this person was an at-risk student program coordinator, superintendent, assistant superintendent, principal, counselor, director of special services, school psychologist, special education director, teacher, or social worker.

As the districts selected were from a random sample, interviewers contacted each district in order until they had a total of 211 complete responses by the designated date for ending survey interviews. The average time spent for each telephone survey ranged from 10 to 45 minutes. Some had no programs and some interviewees wanted to report extensive anecdotal information or talk about their concerns about child abuse. Each interviewee and district were assured that the results of the surveys would be anonymous, other than reporting collective data (for example, percentages of total respondents giving a certain response).

Despite the length of most of the phone interviews, school personnel, by and large, were eager to talk about their views and concerns about the increasing percentages of children who have been abused. Many expressed that they are quite anxious to have workable programs so that they can help children. A small, vocal minority stated that schools should ignore sexual abuse or that it "had never happened in their community."

All states were represented in the random sample except Maine and North Dakota. The following states were not represented in the final sample of 211 districts: Alaska, Delaware, Kansas, Maine, North Dakota, and Rhode Island. The randomly selected districts in Delaware and Rhode Island did not respond to interviewers. All

states had an equal chance to be selected, weighed on the number of the districts in each state.

The definitions of rural, urban, and suburban were read to the interviewees, as needed, and respondents selected the label that most closely fit their district. A number of the 211 district personnel requested a copy of the questionnaire, and it was mailed to interviewees at their district address.

All districts in the random sample were contacted at least once. A total of 211 of the 221 district surveys were usable, for the final analysis.

The questionnaire was designed in a way that respondents would skip questions related to "their district's sexual abuse curriculum," if they reported that they lacked such a program. The poll was designed to be valid with a minimum of 200 respondents, with an 8 percent margin of error.

The study was also designed to determine whether child abuse prevention and treatment services were a district priority, and whether the districts focused on identification of children who had already been abused or emphasized prevention of child abuse. Questions also dealt with program aspects such as what follow-up and support services were provided to children identified, and how frequently programs were evaluated.

SIGNIFICANCE TESTING OF SURVEY DATA

The survey data were examined by programs 7D and 4F of PC90, BMDP Statistical Software. A 5 percent significance level was used throughout for the various tests. If a test was significant at the 1 percent level, the phrase "highly significant" was used in this document.

Program 7D uses analysis of variance procedures to test the null hypothesis that group means are equal. The following tests were run in 7D: Tukey, Bonferroni, Scheffe, Dunnett and Student-Newman-Keuls. Tukey, Bonferroni and Scheffe print significance levels for pairwise mean comparisons. Dunnett prints the significance levels between a control group (in this case, rural) and the remaining groups. Student-Newman-Keuls displays a multiple range test for group means.

Program 7D performs an analysis of variance to assess significance of group differences. Analysis of variance procedures include completely randomized one- and two-way factorial designs based on a fixed-effects model (group sizes need not be equal), and tests to assess group differences when the group variances are unequal.

Program 4F uses the chi-square statistic to test the null hypothesis that the groups are independent. If the test is significant, the null hypothesis is rejected with the conclusion that the groups are not independent.

RATIONALE FOR INITIATION OF THE STUDY

Even though accurate statistics regarding sexual abuse of children and adults are quite difficult to obtain, it is obvious that the rate of sexual abuse of children and adults in our society is appalling, and growing rapidly. In 1985, the National Center on Child Abuse and Neglect estimated that 60,000 to 100,000 children were sexually abused each year. According to Childhelp U.S.A., in 1990, approximately 376,000 American children were reported as sexually abused (Childhelp U.S.A., 1992). It is estimated that one out of three girls and one of every four or five boys experiences sexual abuse by the age of 18. (Children's Safety Network, 1991; Winters, 1985; National Center on Child Abuse and Neglect, 1991; Hart-Rossi, 1984; Finkelhor, 1984; Childhelp U.S.A., 1992; Finney, 1992; Lewis and Rosenfeld, 1991; Vanderbilt, 1992). National studies on prison populations indicate that 80-90 percent of the inmates were abused as children. (Winters, 1985.)

The incidence of sexual abuse is grossly underreported (Vanderbilt, 1992; Finney, 1992). For many reasons, a great number of survivors do not have access to repressed memories concerning their abuse until they are adults, functioning outside of their family, in a relatively independent fashion. For this and many other reasons, it is estimated that most sexual abuse is <u>never</u> reported (Vanderbilt, 1992; Finkelhor, 1984).

The majority (approximately 95%) of child molesters are male (Lewis and Rosenfeld, 1991; Vanderbilt, 1992). Sexual abuse occurs in all racial, ethnic, class, geographic, and cultural groups.

Children should be using the vulnerable years of their youth to develop basic human attributes including trust, self-esteem, risk taking, and the abilities to love and be intimate with other human beings. Surviving incest or a molestation, particularly when it is wrought by a person who is ostensibly the child's caretaker, can be devastating and leave life-long scars. Frequently, survivors consider suicide.

Child abuse, in general, has been strongly linked to domestic violence. For example, a study of 906 children living in battered women's shelters found that nearly 50 % of the children were also victims of sexual and physical abuse (Layzer et al., 1986). Up to 80% of all family violence cases involve drinking alcohol, and almost 30% of children of alcoholics in a study of 200 adults reported an incestuous relationship, particularly with fathers and stepfathers (National Committee for the Prevention of Child Abuse, 1992; American Humane Association, 1988). A landmark study (Finkelhor and Williams, 1992) of 118 incestuous fathers indicated that while 33% reported being under the influence of alcohol when the abuse occurred, and 10% reported that they were using drugs, only 9% held alcohol or drugs responsible. Significantly, 70% of the men said they had been sexually abused in childhood. Half were physically abused by their father, and almost half (44%) had been physically abused by their mother. This study was reported by Vanderbilt (1992).

Females suffer higher rates of abuse than males (Children's Safety Network, 1991; Kohn, 1988; Childhelp U.S.A., 1992; Lewis and Rosenfeld, 1991). According to

some studies, incest among siblings occurs at rates close to that of father-daughter incest (Vanderbilt, 1992).

Low income is a significant risk factor. In 1986, children whose family income was less than $15,000 were four times more likely to be abused than children in higher income families (Layzer et al., 1986). Yet sexual abuse crosses all income, ethnic, and other cultural lines. Stepdaughters are six times more likely to be sexually abused than daughters who live with a natural father. (Russell, 1986; Childhelp U.S.A., 1992; Finkelhor, 1984).

This report will use she/he pronouns, when talking about survivors, to reflect the mixed gender incidence of victimization (one out of three girls, one out of four to five boys). When talking about offenders, the male pronoun will be used to reflect the statistical data indicating that the majority of child molesters are male. This is not intended to minimize the occurrence or impact of sexual abuse by a female offender.

Our society is beginning to be aware of, and to accept ownership for, child abuse. A December 18, 1991 article in U.S.A. Today stated that a study by the Children's Defense Fund reported a rise in national child abuse cases. A survey of 44 states by the Child Welfare League of America found 2.5 million abuse report cases were filed last year, up 150,000 cases from the year before. David Liederman, League Executive Director, reported that abuse cases rise during hard times, and adds that there are not enough government-backed programs for at-risk youth.

Numerous studies have pointed out the difficulty of securing accurate data regarding rape and child abuse. The Senate judiciary committee's Joseph Biden, Jr., Democrat of Delaware, commented on survey methods based on the FBI's Annual Uniform Crime Report. He stated that the report was flawed, and that rape is approaching epidemic proportions. Rape statistics are among the most sensitive and difficult to gather. Dean Kilpatrick of the Crime Victim's Research and Treatment Center in Charleston, SC, agrees that questions aren't worded as well as they could be. For example, one study is conducted by phone, and girls sitting in the living room with their family most likely will not admit that they have been a victim. Only children 12 and older are polled about recent crimes. Yet, studies have shown that 24 percent of all rapes occur before the victim is 11 years old (U.S.A. Today, December 18, 1991, p. 3A).

Finkelhor (1984) reported that physicians were slow to motivate to activism, concerning child sexual abuse because sexual abuse is an emotional subject that sets off conflicts for almost everyone. Rogers (1982) reported that this is because few victims of sexual abuse show "medically significant" physical trauma, and physicians are trained to minister to physical ailments. Finkelhor (1984) reported that conditions that do not pose major medical challenges (e.g., sexual abuse) fall outside the interest of most physicians.

The American Medical Association on January 16, 1992 issued the first guidelines for doctors dealing with child abuse. Doctors have heretofore considered family violence a taboo subject for discussion with patients. The new guidelines urge

doctors to keep careful records and to be nonjudgmental, but to safeguard the child as first priority. Dr. Robert McAfee, Vice President of the AMA's Board of Trustees, reported that "currently doctors do a terrible job of recognizing battered spouses, and abused children." He reported that most victims want to tell doctors and would prefer to tell them than a pastor or rabbi (U.S.A. Today, January 17, 1992, p. D1). The guidelines advise doctors to:

*take emergency steps
*hospitalize a child at-risk
*record injuries and relevant facts in detail
*remain objective, and
*keep communication open with the family
(U.S.A. Today, January 17, 1992, Pg. D1.)

This progress has merit. However, whether or not hospitalization is necessary, reporting abuse is a legal requirement, as per state laws passed in response to P.L. 93-247, the federal Child Abuse Prevention and Treatment Act, passed in 1974. Physician training programs should include comprehensive training regarding the recognition, reporting, and treatment of child sexual abuse. Training should also emphasize that identification and reporting are only the first steps in a child's healing. The family and the child need counseling and other follow-up services.

The U.S.A. Today January 17, 1992, article reported that social and gender inequality and cultural support of violence are underlying causes of family violence. It is interesting that cultural support of violence and social and gender inequity cause violence. Gender inequity is also symptomatic of violence in our society.

Children raised in abusive environments are at high risk for physical and emotional health problems, as well as developmental delays and school-related problems (Hochstadt et al., 1987). The 1991 report of the National Commission on Children reported that children who have experienced violence and exploitation enter adulthood without the skills or motivation to contribute to society. They may be poorly equipped to reap the benefits or meet the responsibilities of parenthood, citizenship, and employment. The consequences of their problems will reach far beyond their personal lives. America's future as a democratic nation, a world leader, and an economic power will depend as much on youth who have been abused as it will on those who are more advantaged. For them, and for the nation, the years to come will be less safe, less caring, and less free, unless appropriate actions are taken (Beyond Rhetoric, 1991).

As the National Commission's report concluded, action must be thoughtful, broad-based, and sustained. The problems that plague our society have evolved over time, and they will not disappear overnight. Solutions will depend upon strong leadership and the concentrated efforts of every sector of society. This includes individuals, employers, schools, civic, community and religious organizations, and government at every level. Creative public policies and private sector practices, wise investments of public and private resources, and significant commitment of individual time and attention to the needs of children and their families, are required.

Comprehensive community level approaches to strengthen families were recommended in the report (Beyond Rhetoric, 1991).

Increasing numbers of children are running away from family conflict and sexual abuse as well as other violence. Such children are in great danger of homelessness and of additional sexual and physical abuse while "on the road." Many (particularly illegal aliens and minority migrant children) face language, bicultural, and legal barriers.

One reason that sexual abuse is underreported is that the majority of children repress memories of their abuse. This is necessary for their survival. Young people who are aware of their abuse frequently fear the potential involvement of child protective service workers, police, and repercussions from family members and neighbors. Children fear that their truth will not be believed. Thus, studies have indicated that children are not likely to openly discuss their abuse (National Network of Runaway and Youth Services, 1991; Vanderbilt, 1992).

Young people who engage in survival sex (prostitution) are especially at-risk for physical violence, rape, sexually transmitted diseases (including HIV), and pregnancy. This is especially relevant today, as the number of children who are homeless and who run away or are kicked out of their home increases. Estimates have indicated that as many as 99 - 100 percent of youth who engage in survival sex have been sexually abused (National Network of Runaway and Youth Services, 1991). According to Zierler et al. (1991), childhood sexual abuse predisposes the victim to participation in a number of high risk adolescent behaviors regarding HIV infection (e.g., truancy, sexual promiscuity, and chemical dependency).

DEMOGRAPHIC DATA

Of the 211 districts in the survey, 141 (67%) were rural, 19 (9%) were urban, and 51 (24%) were suburban. These percentages are compatible with the percentages of rural, urban, and suburban districts across the U.S.

Table 1 below indicates the positions of the respondents to the survey. The interviewer asked to speak to the person designated as in charge of the district's at-risk student program. Some district personnel were unclear who that individual was. Once the distinction was made, generally, that person was available. Thus, these data provide a general view of which positions are designated as having authority over programs for children who are at risk, in rural, urban, and suburban districts.

Table 1
Positions of Survey Respondents

Position	Total	Rural	Urban	Suburban
Superintendent	18.0%	24.8%	5.5%	3.9%
Principal	8.5%	12.8%	0.0%	0.0%
Assistant Supt.	14.2%	12.1%	0.0%	25.5%
Dir. of Special Serv.	9.0%	5.7%	15.8%	15.7%
Counselor	10.9%	14.9%	0.0%	3.9%
Special Ed. Director	1.9%	0.7%	5.2%	3.9%
Teacher	1.0%	0.7%	0.0%	2.0%
School Psychologist	2.9%	3.5%	0.0%	2.0%
Other	33.6%	24.8%	73.7%	43.1%

Urban districts (5.5%) were far less likely than rural districts (24.8%) to designate a superintendent as responsible for at-risk programs. Although rural (24.8%), suburban (43.1%), and urban (73.7%) districts all frequently designated "other," which was an at-risk program coordinator or a social worker, urban districts were three times as likely as rural districts to specifically name "at-risk coordinator."

The data indicated the higher frequency of having an at-risk coordinator or social worker available to an urban district. These data are consistent with other studies indicating that rural districts tend to have inadequate funding for such specialized positions and that superintendents, principals, and counselors play broader (less specialized) roles in rural than in non-rural districts. To illustrate this point, the data are rearranged in Table 2 below, by frequency of positions noted.

Table 2
Frequency of Positions Named as Responsible for At-Risk Programs
(Positions are listed in order of decreasing frequency)

Total		Rural		Urban		Suburban	
Other*	33.6%	Supt	24.8%	Other*	73.7%	Other*	43.1%
Supt.	18.0%	Other*	24.8%	Dir. Sp.Sv.	15.8%	Asst. Supt.	25.5%
Asst. Supt.	14.2%	Counselor	14.9%	Supt.	5.5%	Dir. Sp.Sv.	15.7%
Counselor	10.9%	Principal	12.8%	Sp Ed Dir	5.2%	Supt.	3.9%
Dir. Sp. Sv.	9.0%	Asst. Supt.	12.1%	Teacher	0.0%	Counselor	3.9%
Principal	8.5%	Dir. Sp.Sv.	5.7%	Principal	0.0%	Sp. Ed. Dir.	3.9%
Sch. Psy.	2.9%	Sch. Psy.	3.5%	Asst. Supt.	0.0%	Teacher	2.0%
Sp. Ed. Dir.	1.9%	Teacher	0.7%	Counselor	0.0%	Sch. Psy.	2.0%
Teacher	1.0%	Sp. Ed. Dir.	0.7%	Sch. Psy.	0.0%	Principal	0.0%

*Other = at-risk coordinator or social worker.

These data also indicate that a special education director, school psychologist, or teacher is seldom designated by any type of district. These data are generally consistent with one of the last questions reported in this report, "who are the primary liaisons between the school district and community support services?"

EXISTENCE OF DISTRICT PROGRAMS

Interviewees were asked, "Is there a formal sexual abuse prevention and treatment program implemented in your district?" Table 3 below indicates responses to this question.

Table 3
Districts Having Sexual Abuse Prevention and Treatment Programs

	Total	Rural	Urban	Suburban
# Respondents	211	141	19	51
No	51.7%	54.6%	42.1%	47.1%
Yes	48.3%	45.4%	57.9%	52.9%

In spite of the facts that one in three girls and one in four or five boys are sexually abused by age 18, 51.7% of the surveyed districts did not have prevention and treatment programs. Urban (57.9%) and suburban (52.9%) districts were more likely than rural districts (48.3%) to have programs.

STATE MANDATED PROGRAMS

Districts stating that they had a formal sexual abuse prevention and treatment program in their district were asked, "Is this mandated by your state?" This question was designed to determine the percentage of districts that had prevention and treatment programs, even though such programs were not mandated by their state. Table 4 below indicates responses to this question.

Table 4
Is Your District's Program Mandated by the State?

	Total	Rural	Urban	Suburban
No	63.5%	61.0%	68.4%	68.6%
Yes	29.9%	29.8%	31.6%	29.4%
Unsure	6.6%	9.2%	0.0%	2.0%

According to respondents, 14 states (28%) mandated districts to have child sexual abuse prevention and treatment programs. Interviewees within a given state reported so much confusion regarding this point that investigators in the study consulted with the National Clearinghouse on Child Abuse and Neglect staff. Investigators acquired and read legislation and administrative codes, from all 50

states, related to the 1974 Child Abuse Prevention and Treatment Act, P.L. 93-247. Even in states with the most comprehensive and best designed legislation and administrative codes, districts are "encouraged," versus "required" to have programs. Most states have no child abuse education and training guidelines for preservice teacher education. Only two states have a required number of hours and topical areas regarding child abuse education required for teacher certification. Most states "encourage" district training regarding reporting abuse. Some do not even do this even though states' administrative codes state that educators are required to report abuse to legal authorities. (Twelve states require "some" training regarding how to report abuse.)

GROUPS TRAINED IN SEXUAL ABUSE AND PREVENTION

Respondents who stated that their districts have sexual abuse and prevention programs were asked to estimate the percentage of school staff, parents, students, and community citizens that have received training in sexual abuse prevention and treatment. Table 5 below depicts answers to this question. All percentages represent mean percentages estimated by respondents.

Table 5
Persons Receiving Training in Sexual Abuse and Prevention

	Total	Rural	Urban	Suburban
Administrative Staff	69.5%	70.7%	47.4%	76.2%
Special Educators	70.1%	71.9%	55.5%	71.5%
General Ed. Teachers	67.2%	68.7%	52.5%	69.8%
Other Support Personnel	43.1%	43.0%	37.2%	46.0%
Community Citizens	7.9%	8.6%	10.9%	4.0%
Parents	10.2%	10.9%	13.4%	6.4%
Students	55.2%	54.2%	43.8%	63.7%

Median, mode, and frequency data were analyzed for rural, urban, and suburban districts in each category. They are not reported here because they are consistent with the means data reported here. (This is true for other questions throughout this report.)

In general, special educators, administrators, and general education teachers most frequently received training in sexual abuse prevention and treatment curriculum. Such individuals received some training in a majority (over 50%) of districts surveyed. Rural and suburban districts surpassed their urban counterparts in providing training (an average of 70.4% rural, 72.5% suburban, and 51.8% urban districts).

Training to the target population of students was reported by only 43.8% of urban, 54.2% of rural, and 63.7% of the suburban districts surveyed.

Training for the category of "other support personnel" (counselors, social workers, nurses, and school psychologists) was provided by only 37.2% of urban, 43.0% of

rural and 46.0% of suburban districts. This is unfortunate for many reasons including the fact that the job descriptions of such personnel include providing student counseling. Individuals in these positions are also expected to support the efforts of educators and administrators as they implement programs.

It is essential that community citizens and parents be educated and enlisted as allies to win the battle against child sexual abuse. Yet, only 4.0% of suburban, 8.6% of rural, and 10.9% of urban districts, reportedly trained community members. Only 13.4%of urban, 10.9% of rural, and 6.4% of suburban districts trained parents. These findings are also disturbing because this question was only asked of personnel in the 48.3% of all districts that stated that they do have a sexual abuse prevention and treatment program. A number of district respondents stated, "although there is great need, there is little involvement of community citizens and parents."

Anecdotal comments given in response to this question indicated that some district respondents previously stating that they had prevention and training programs probably did not. Examples of such comments follow.

"Sexual abuse is not the school's business."
"Sexual abuse is not a problem in our district."
"If we were to identify sexual abuse, we would make a referral to an outside resource."
"There is no program, curriculum, training, or education."
"We meet the needs of a religious community. Sexual abuse issues are not addressed."
"We have no staff training or education."
"We have no sexual abuse curriculum or program in our district."
"Date rape is covered in 11th grade health curriculum."

POSITIONS INVOLVED IN PROGRAM PLANNING AND IMPLEMENTATION

Respondents were asked to identify persons involved in planning and implementation of their district's sexual abuse curriculum. Table 6 below indicates their responses.

Table 6
Persons Involved in Program Planning and Implementation

Position	Total	Rural	Urban	Suburban
Superintendent	52.9%	55.8%	56.2%	42.9%
Principal	77.4%	79.8%	87.5%	65.7%
Teacher	71.0%	66.3%	87.5%	77.1%
Case Mgmt Team	27.7%	25.0%	62.5%	20.0%
Counselor	84.5%	90.4%	87.5%	65.7%
School Psych.	44.5%	41.3%	87.5%	34.3%
Nurse	65.2%	61.5%	87.5%	65.7%
Social Worker	34.8%	28.8%	62.5%	40.0%
Other	23.2%	15.4%	62.5%	28.6%

Direct service personnel and administrators at the building level were most frequently involved in planning and implementation of sexual abuse programs. Such personnel included principals, teachers, counselors, and nurses. A majority of urban districts with sexual abuse programs also involved social workers (62.5%) and school psychologists (87.5%). Only 42.9% of suburban, 55.8% of rural, and 56.2% of urban districts with programs reported involving superintendents.

Urban districts involved the highest percentages of most personnel and were most likely to have a formal case management team including an at-risk coordinator (noted in the "other" category). Urban districts, due to the numbers of children served, are the most likely to have funding for specialized personnel including school psychologists and social workers and at-risk program coordinators. The data support this fact.

Suburban districts (20.0%) and rural districts (25.0%) seldom employed a formal case management team. In rural districts, this may be related to smaller numbers of students in the district and fewer funds for at-risk programs. It is important to note that other national studies have indicated that higher percentages of rural than urban children tend to be at risk (Children's Defense Fund, 1992; Helge, 1991). The highest percentages of personnel reported by suburban districts to be involved in program planning and implementation were teachers, principals, counselors, and nurses. (Suburban districts were, however, less likely than urban or rural districts to involve counselors.)

Almost all of the rural (90.4%) districts with programs reported involving counselors. They also most frequently involved principals (79.8%), and only 66.3% reported involving teachers.

Only 34.3% of suburban and 41.3% of rural districts reported involving school psychologists. Likewise, only 28.8% of rural, 40.0% of suburban, and 62.5% of urban districts reported involving social workers.

According to chi square tests, the following groups were significantly different, regarding involvement in a district's program planning and implementation efforts.

Case management team:	Rural versus Urban: highly significant Suburban versus Urban: highly significant
Counselor:	Rural versus Suburban: highly significant
School psychologist:	Rural versus Urban: highly significant Suburban versus Urban: highly significant
Social Worker:	Rural versus Urban: significant
Other (at-risk coordinator):	Rural versus Urban: highly significant Suburban versus Urban: significant

Please note that these data were only reported by districts stating that they have an ongoing sexual abuse program. The question asked, "which of the following are involved, if at all."

FREQUENCY OF PROGRAM OFFERING

District respondents were asked to estimate the amount of time that their prevention and treatment program is offered. Table 7 indicates their responses to this question.

Table 7
Frequency of Offering of Sexual Abuse Prevention and Treatment Programs

Frequency	Total	Rural	Urban	Suburban
1x/year	45.9%	49.5%	50.0%	33.3%
1x/semester	18.5%	19.6%	18.8%	15.2%
1x/month	1.4%	2.1%	0.0%	0.0%
1x/week	2.1%	2.1%	0.0%	3.0%
Ongoing	32.2%	26.8%	31.3%	48.5%

As indicated in Table 7 above, respondents of suburban districts that had programs felt that their programs were integrated into ongoing school curriculum more frequently (48.5%) than did rural (26.8%) or urban (31.3%) programs. The majority of urban (50.0%) and rural (49.5%) program respondents reported that their programs were offered once per year.

Note: 54.6% of rural, 42.1% of urban, and 47.1% of suburban districts did not offer sexual abuse prevention and treatment programs. Of responding districts with programs, almost half (45.9%) offered them only once per year, and almost one-third (32.2%) reported that their programs were an ongoing part of their school curriculum. Progress is being made in that programs are being offered such as those encouraging children to "say no" to or to report abuse. However, children must be continuously supported in their efforts to say no to, or to report, abuse. A total of 51.7% of all districts reported that they have no program.

PROGRAM TIME BEYOND STATE MANDATE

Respondents were asked if the amount of time that their program is offered is beyond their state's mandate. Table 8 below indicates responses to this question.

Table 8
Is the Amount of Program Time Beyond the State Mandate?

	Total	Rural	Urban	Suburban
yes	49.0%	46.0%	66.7%	50.0%
no	51.0%	54.0%	33.3%	50.0%

This question was asked only of those districts (48.3%) responding that they have a sexual abuse prevention and treatment program. Two-thirds (66.7%) of the urban

districts reported that their programs surpassed requirements of a state mandate for a sexual abuse program. Half (50%) of the suburban and almost half (46%) of the rural programs reported surpassing state mandates. As the state analysis indicated, states actually "encourage" and do not "mandate." Thus, even a district with a minimal program would surpass the "state mandate." The lack of state mandates was unknown before state administrative codes were reviewed after study investigators noticed inconsistencies and confusion, expressed by respondents.

LEVEL OF COMMUNITY SUPPORT FOR PROGRAM

Respondents were asked if they felt their sexual abuse programs were supported or tolerated by the community. Table 9 below depicts answers to this question. Participants were allowed to answer "both supported and tolerated by the community."

Table 9
Level of Community Support for Program

	Total	Rural	Urban	Suburban
Supported	79.7%	74.7%	86.7%	91.2%
Tolerated	16.7%	20.2%	13.3%	8.8%
Both	3.4%	5.1%	0.0%	0.0%

Suburban (91.2%) and urban (86.7%) programs were more likely to be perceived as supported than were rural district programs (74.7%). One-fifth (20.2%) of the rural district respondents felt that their programs were merely "tolerated," or were supported by some community citizens while tolerated by others (5.1%).

Rural areas may tend to be less supportive of child sexual abuse prevention or treatment programs than non-rural areas. Other studies have found that controversial or non-traditional efforts, such as sex education, are not as well received in rural, as in non-rural areas. This points out the need to educate rural (and other) communities about the extent of child sex abuse and the need for prevention and treatment efforts.

COMFORT LEVEL OF STAFF TEACHING CURRICULUM

Interviewees were asked the comfort level of persons teaching the curriculum (for example, answering difficult questions). The choices were "very comfortable," "moderately comfortable," and "not very comfortable." Table 10 below summarizes the answers to this question.

Table 10
Comfort Level of Staff Teaching Curriculum

	Total	Rural	Urban	Suburban
Very	55.2%	49.0%	81.2%	60.6%
Moderately	40.7%	44.8%	18.8%	39.4%
Not	4.1%	6.2%	0.0%	0.0%

Although 81.2% of urban respondents perceived that their programs involved personnel who were "very comfortable" dealing with sexual abuse and treatment, only 60.6% of suburban, and 49.0% of rural respondents reported this degree of comfort. Almost half (44.8%) of respondents in rural districts and 39.4% in suburban districts were only "moderately" comfortable. The chi square test indicates that the rural versus urban difference is significant.

Although the great majority of urban district respondents with programs (81.2%) reported that their personnel were "very comfortable," rural and suburban district personnel were reported as only "moderately" so.

It is imperative that personnel dealing with prevention and treatment programs be comfortable discussing sexual abuse issues. It is possible that staff in urban areas, who typically would have more anonymity than staff in rural or suburban areas, would feel more comfortable openly dealing with such issues. It is possible that most local citizens are more openly comfortable discussing sexual abuse issues and/or being known as "the community sex educator." Concepts such as sexual abuse are more widely discussed in many urban areas. Students are more likely to divulge abuse and to receive appropriate assistance if educators are comfortable discussing related topics. Relevant staff development and community education programs are needed.

FOCI OF DISTRICT PROGRAMS

Interviewees were asked to designate the foci of their sexual abuse prevention and treatment programs from the list in Table 11 below. Respondents selected as many foci as were appropriate in their district. Table 11 below depicts data gathered.

Table 11
Program Foci in Districts with Sexual Abuse Programs

	Total	Rural	Urban	Suburban
Refusal Skills	79.7%	78.8%	80.0%	82.4%
Prevention	89.2%	87.9%	93.3%	91.2%
Early Identification	67.6%	66.7%	86.7%	61.8%
Treatment	50.0%	54.5%	33.3%	44.1%
Teacher Training	64.2%	62.6%	73.3%	64.7%

Generally, districts that had programs emphasized prevention and refusal skills. Urban respondents reported a higher emphasis (86.7%) on early identification than did rural (66.7%) or suburban (61.8%) districts.

Urban districts reported a low emphasis on treatment (33.3%) as did suburban districts (44.1%), and only slightly more than half of the rural districts reported that treatment was a program emphasis. As identification is only the first of many steps involved in helping children heal from sexual abuse, and 51.7% of all districts

reported having no programs, treatment and other follow-up efforts definitely appear to be inadequate.

Although it is essential to teach refusal skills and to emphasize prevention of sexual abuse, a realistic approach to sexual abuse is essential. School personnel have, in the past, generally been unaware of the extent of child sexual abuse. Recently, many school planning committees have assumed that teaching children to "just say no" to sexual abuse would solve the problem or that parents should teach children how to prevent abuse, or should stop abuse, if it occurs.

Our society has not yet been adequately educated about the problem and circumstances surrounding sexual abuse. It is unrealistic to think that children have been empowered to refuse those in power. Most frequently, perpetrators are family members with power over dependent children. These children typically are confused and feel guilty about being abused by a person upon whom they are dependent and have little, if any, power to "say no."

Schools that are teaching refusal skills on an ongoing basis (not via a once-a-year assembly) are making an excellent first step to prevent abuse. Teaching the right to refuse abuse once a year or in only some grades will have few results. This is particularly true if teachers are not very comfortable discussing sexual abuse issues.

To survive the emotional and physical damage of sexual abuse, most children leave their bodies (disassociate) and repress inappropriate touching and/or penetration. Most abused children feel guilty about the abuse. Typically, they have been told by perpetrators that the actions inflicted upon them were "their fault," "for their own good," or that "they wanted or liked it." Most were also told that adults will not believe them if they tell; that Mom or Dad won't love them anymore; that they will get in trouble, be sent away; and/or that something terrible will happen to them or to their parent, if they tell. The keys to preventing the child from divulging abuse involve convincing the child that the violation is an act which must be kept secret, shaming the child, and creating a bond of fear to protect the offender. Children require consistency and repetition to assimilate most new knowledge or skills. This is particularly true when the subject is sexual abuse by a person who has power over the child.

As the child's trust of adults has been broken by the perpetrator, it is very difficult for the child to trust that another adult will believe and/or help them. Many spouses or partners of offenders find it difficult to acknowledge abuse. Thus, the roles of schools and the community have become much more essential.

School and community members must be made aware of these factors and design realistic programs. These programs should involve consistently educating children and the community that sexual abuse is illegal and not "ok." The programs should encourage children to tell responsible adults and to create trust that adults will help them. There will always be some adults who are preoccupied or for other reasons cannot hear the child. Children are generally confused and ashamed to share information about the violation. Many children tell their secret carefully and subtly. Because most children have repressed most of what happened to them, their

statements may be, and sound, confused. Thus, adults must be trained to read subtle and direct clues of abuse.

Some adults find it too painful to hear about abuse and are unable to help a child. Thus, children need to be encouraged to tell another adult, if the first does not act, and reminded that the abuse was not the child's fault. Adults should be made aware that only rarely will a child state an untruth about abuse, and that generally that will be a result of confusion due to manipulation by an offender. So much shame is involved in admitting that abuse has occurred, that the vast majority of children will never lie about it (Goodman, 1990). Stating that abuse has occurred is clearly a cry for help from responsible adults.

Children who are not heard, those who fear they will not be heard, and those feeling the depths of their shame, frequently experience suicidal thoughts, or at the least, isolate themselves from their feelings. Such children definitely cannot learn as well as they would otherwise. For such reasons, a strong treatment (follow-up) program is essential for children whose abuse is identified.

Only 33.3% of the urban, 44.1% of the suburban, and 54.5% of the rural districts stated that treatment (follow-up) was a program emphasis. (The question did not ask what follow-up was a program foci, and only 48.3% of all districts surveyed had any program.)

Uncovering the abuse is only the first step in a long healing process for an abused child. Particularly because most abuse happens by a family member, it is essential that children be consistently supported by school and community personnel. Case management and/or other follow up techniques, implemented by concerned, reliable adults should confidentially assist the child. Sexual abuse is extensive in our society, and a family member is usually the offender. Thus, schools must play a major role in assisting children's recovery. This is especially true if we are to produce children who do have the inalienable rights set forth in the U.S. Constitution and if our next generation of American adults are to have the emotional stability to be productive citizens.

A total of 73.3% of urban, 64.7% of suburban, and 62.6% of rural districts reported that their programs included teacher training. This indicates that districts are recognizing that teachers must receive at least some training to fulfill their roles. The question did not ask how much training. Also, please note that 51.7% of all districts surveyed had no program.

TOPICS INCLUDED IN INSERVICE EDUCATION

Respondents were asked to note which topics were included in their staff inservice education program. Interviewees were asked to select from the topics in the list depicted in Table 12 below.

Table 12
Topics Included in Inservice Education Program

	Total	Rural	Urban	Suburban
How Report	91.9%	92.9%	94.7%	87.8%
Confidentiality Procedures	85.2%	86.5%	89.5%	79.6%
How ID Students	82.8%	80.9%	89.5%	85.7%
How ID Families	61.2%	58.9%	84.2%	59.2%
Plan with Community	46.4%	46.1%	47.4%	46.9%
Parent Involve.	46.4%	44.7%	52.6%	49.0%
School Policy Development	56.5%	57.4%	68.4%	49.0%
Self-esteem Resources	72.7%	76.6%	63.2%	65.3%
Academic Assistance	52.6%	49.6%	57.9%	59.2%

As reported above, 51.7% of all districts surveyed had no program. Of the 48.3% answering this question, an average of 64.2% (62.6% rural, 64.7% suburban, and 73.3% urban) indicated that their program included an inservice training focus.

The vast majority of schools reported inservice training regarding how to report sexual abuse (94.7% urban, 92.9% rural, and 87.8% suburban). Similarly, a clear majority of districts reported inservice training regarding how to identify abused students (89.5% urban, 85.7% suburban, and 80.9% rural) and confidentiality procedures (89.5% urban, 86.5% rural, and 79.6% suburban).

Thus, the basics of how to identify and report abuse in a confidential manner appear to be covered by most inservice programs in some fashion. These are not prevention or treatment themes, but involve meeting legal requirements of school personnel.

The next highest percentage regarding a topic was "student self-esteem resources," with 76.6% of rural, 65.3% of suburban, and 63.2% of urban districts covering this topic. In an earlier question, rural districts reported an emphasis on "treatment" more frequently than did urban or suburban districts. Regarding another element of treatment, "academic assistance programs" was included as a topic by 59.2% of suburban, 57.9% of urban, and 49.6% of rural districts. Although academic performance is generally affected and academic assistance resources are required, healing from sexual abuse requires a great deal of work in the area of self-esteem development.

School policy development was an inservice topic reported by the majority of surveyed districts (68.4% urban, 57.4% rural, and 49.0% suburban). This item

reflects a concern by districts that a consistent policy addressing potential legal requirements be in place. It may also reflect a concern for student welfare.

Topics mentioned less frequently were "planning with community involvement" (47.4% urban, 46.9% suburban, and 46.1% rural), and "parent involvement" (52.6% urban, 49.0% suburban, and 44.7% rural). These two items are more prevention oriented. Another topic of a preventive nature was "identification of families at risk" for abusing children. While 84.2% of the urban districts surveyed reported addressing this topic, a substantially lower majority of suburban (59.2%) and rural (58.9%) districts reported addressing it.

Thus, legal requirements of identifying and confidentially reporting sexual abuse appeared to be the highest priorities of respondents' programs (versus prevention or treatment themes). Urban districts, however, also prioritized identification of potentially abusive families, which is a prevention-oriented theme.

The next level of priority (prevention and treatment oriented) was "student self-esteem resources," led by the interest of rural districts. This priority was followed by suburban and rural districts' identification of potentially abusive families (prevention oriented).

The next items of priority were school policy development and academic assistance. Lower priorities were "program planning with community involvement" and "parent involvement."

Most of these results regarding inservice topics are consistent with more conventional roles of schools to meet state and federal requirements versus directly addressing social issues. It is interesting that urban areas, with perhaps fewer opportunities to identify families at risk, covered this topic more than rural and suburban districts, where families generally have less anonymity. Other studies have indicated that the lack of anonymity and the difficulty of maintaining confidentiality in most rural areas may inhibit reporting child abuse. It appears that the "new" roles of schools (e.g., intervention in "family problems") are not yet apparent in the priorities of school inservice programs.

STAFF SUPPORT PROCEDURES

Interviewees were asked what procedures their districts use to support their staff who experience difficulty when sexual abuse issues are discussed. Responses are indicated in Table 13 below. Interviewees could specify as many responses as were appropriate for their district.

Table 13
Procedures to Support Staff with Difficulty with Sexual Abuse Issues

	Total	Rural	Urban	Suburban
Refer to Counseling	50.2%	52.9%	47.4%	43.7%
Offer Counseling	41.5%	41.3%	36.8%	43.7%
No Procedures	24.9%	24.6%	21.1%	27.1%
Other	13.2%	8.7%	26.3%	20.8%

The problem of child sexual abuse is not new, although it is growing rapidly. The perceptions of the roles of schools and the larger community are shifting. Many adults were also sexually abused, and it is only now that society is openly discussing this issue. Many adults, including educators, have never dealt with their own pain about their sexual abuse. It is extremely difficult for teachers who have not confronted their own pain to comfortably and effectively assist students.

School officials, when presenting inservice sessions regarding child abuse, sometimes find that many teachers are uncomfortable discussing this topic due to reasons such as those mentioned above. Others may simply be uncomfortable discussing sex in public.

Roughly half (50.2%) of the respondents in this survey (52.9% rural, 47.4% urban, and 43.7% suburban) refer employees to counseling services, and 41.5% (43.7% suburban, 41.3% rural, and 36.8% urban) offer counseling.

Some districts have access to state or locally funded employee assistance programs that offer a certain number of free counseling sessions to school employees, with the promise of confidentiality. Some refer to community mental health services, generally available at some fee, perhaps on a sliding-scale basis.

Districts offering counseling in-house face a variety of issues. Sometimes "counseling" merely involves a discussion concerning an employee's belief system that means that he or she does not choose to be involved in the district's prevention and treatment program (if that is an option). Because "counseling" by definition offers confidentiality to a client, it is generally difficult to justify counseling for a district employee, within the school district. Lack of confidentiality and concerns about job security are only two factors involved. Some anecdotal comments indicated that a teacher having difficulty discussing sexual abuse would be sent to talk to the school superintendent or principal.

Counseling regarding sexual abuse requires a great deal of vulnerability on the part of a survivor of molestation or incest, and generally is not achieved in only a few counseling sessions. Confidentiality is required. In addition, most survivors are female and the majority of school administrators are male. Counseling is ideally an experience with a counselor selected by the client, and sometimes whether a counselor is male or female is an important variable to a client.

Some respondents also reported that survivors were referred to a district "debriefing" or crisis intervention team, or to a student assistance team or to a district social worker or counselor. Typically, employees who are adult survivors and have not previously dealt with their pain will feel quite uncomfortable talking to a school district group of peers or to a peer staff member.

Some respondents commented that the person was referred to a district inservice on sexual abuse (a subject in which the survivor is already well versed). A number of respondents stated, "No one in our district has ever had difficulty."

Of particular importance regarding this question, one-fourth (an average of 24.9%) of the respondents reported that their district has "no procedures" for supporting staff who have difficulty with sexual abuse issues. Staff who are uncomfortable and have not received support will experience difficulty assisting children. Children learn from adults, primarily as role models, and not from the words adults say. Children make decisions based on their feelings, much more than on the facts they are told. If they are expected to divulge and be vulnerable enough to heal, we owe them the availability of staff who are comfortable and capable of assisting them. Thus, this issue must be addressed in the context of increased school roles and decreased budgetary resources.

PARENTAL ABILITY TO EXCUSE STUDENTS FROM SEXUAL ABUSE PROGRAM ACTIVITIES

Interviewees were asked to state whether student attendance at activities was compulsory or if parents could excuse their children from activities regarding sexual abuse. Responses to this question are indicated in Table 14 below.

Table 14
May Parents Excuse Children from Sex Abuse Education?

	All	Rural	Urban	Suburban
Compulsory	15.2%	14.0%	18.8%	17.1%
Optional	84.8%	86.0%	81.2%	82.9%

Only 48.3% of all of the districts surveyed have a sexual abuse program. The vast majority of these respondents (86.0% rural, 81.2% urban, and 82.9% suburban) indicated that parents may excuse their children from activities regarding sexual abuse education.

As most sexual abuse occurs within the nuclear family and most victims are told not to tell the "secret," the implications of allowing parents to control the child's sources of information and assistance are obvious.

ASSESSMENT OF PROGRAM EFFECTIVENESS

Respondents were asked to assess the effectiveness of district efforts, relative to the district's objectives for preventing and treating child sexual abuse.

This question was asked of the 48.3% of the programs stating they had a sexual abuse prevention and treatment program. The question assumes that the district has program objectives. Interviewers did not ask the basis for respondents' evaluations. Table 15 below indicates responses to this question.

Table 15
Respondents' Perceptions of Their Program's Effectiveness

	Total	Rural	Urban	Suburban
Excellent	7.1%	3.8%	14.3%	14.7%
Above Average	37.8%	37.7%	35.7%	35.3%
Average	46.8%	48.1%	50.0%	41.2%
Below Average	8.4%	10.4%	0.0%	5.9%
Poor	0.6%	0.0%	0.0%	2.9%

Almost half of the respondents rated their programs as "average" (48.1% rural, 50.0% urban, and 41.2% suburban). Close to one-third (37.7% rural, 35.7% urban, and 35.3% suburban) rated their programs as "above average." Close to 15% of suburban (14.6%) and urban (14.3%) rated their programs as "excellent," and about one-tenth (10.4%) of rural respondents rated their programs as "below average."

FREQUENCY OF PROGRAM EVALUATION

Respondents were asked how frequently their programs were evaluated. Table 16 below depicts answers to this question.

Table 16
Frequency of Program Evaluation

	Total	Rural	Urban	Suburban
Less than 1x/year	20.1%	19.3%	26.7%	20.0%
1x/year	39.6%	39.4%	33.3%	42.5%
1x/semester/qtr.	1.8%	1.8%	0.0%	2.5%
No. Eval.	38.4%	39.4%	40.0%	35.0%

As indicated in Table 16 above, formative evaluation, an approach that would facilitate program change based on program evaluation, occurs in few (if any) districts.

Of the districts having programs, 40.0% of urban, 39.4% of rural, and 35.0% of suburban districts do <u>not</u> evaluate their programs. Furthermore, 26.7% of urban,

20.0% of suburban, and 19.3% of rural programs evaluate programs less than once a year. An average of 39.6% of the respondents (42.5% suburban, 39.4% rural, and 33.3% urban) evaluate programs once a year, and an average of only 1.8% of the districts surveyed evaluate their programs once per semester or quarter.

Although the question did not ask how programs are evaluated, evaluation that occurs less than once per year provides little useful information for timely restructuring (e.g., change of approaches, incorporation of new knowledge, etc.). Program evaluation does not appear to be a priority of district programs.

COMPONENTS OF DISTRICT PROGRAMS

Respondents were asked to identify which of the components in Table 17 below are included in their district's sexual abuse prevention and treatment program.

Table 17
Components of District Programs

	Total	Rural	Urban	Suburban
Crisis Counseling	69.5%	70.2%	76.5%	65.1%
Self-esteem	73.0%	74.6%	76.5%	67.4%
Education About Feelings	75.3%	72.8%	94.1%	74.4%
Identification of Feelings	64.4%	58.8%	82.4%	72.1%
Processing of Feelings	57.5%	55.3%	64.7%	60.5%
Tutoring	29.9%	34.2%	17.6%	23.3%
Counseling	69.0%	71.9%	70.6%	60.5%
Vocational Education	40.2%	43.0%	47.1%	30.2%
Social Services	58.0%	60.5%	58.8%	51.2%
Family Ed/ Involvement	48.3%	46.5%	64.7%	46.5%
Local Planning Committee	35.1%	34.2%	35.3%	37.2%
HIV/AIDS Ed	69.9%	64.0%	64.7%	67.4%
Community Ed	32.2%	30.7%	47.1%	30.2%
Empowering Students	49.4%	43.9%	58.8%	60.5%
Communica-tion Skills	59.8%	57.0%	70.6%	62.8%
Recreational Alternatives	35.1%	34.2%	47.1%	32.6%
Drama	22.4%	19.3%	35.3%	25.6%

Movement/ Dance	10.3%	7.0%	29.4%	11.6%
Art Therapy	12.1%	11.4%	17.6%	11.6%
Music Therapy	7.5%	6.1%	11.8%	9.3%
Comprehen-sive Health Services	39.1%	38.4%	52.9%	34.9%
Sex Education	64.9%	59.6%	82.4%	72.1%
Drug & Alcohol Abuse Ed.	75.3%	75.4%	88.2%	69.8%
ESL	29.9%	24.6%	58.8%	32.6%
Multi-Cultural Education	33.9%	28.9%	58.8%	37.2%
Peer Support	50.6%	49.1%	76.5%	44.2%
Teacher Support Sys.	46.0%	40.4%	58.8%	55.8%
Case Manage-ment Teams	38.5%	33.3%	70.6%	39.5%
Other	2.3%	2.6%	0.0%	2.3%

The above program components were selected after discussions with therapists and sexual abuse survivors, as well as reviews of case histories of survivors and related literature. The intention of the question was to discern whether services recommended for survivors (other than private therapy) were offered by school districts. As case histories indicated, services would need to be individualized for different students. Yet a variety of well-rounded options should exist for the academic, emotional, and physical needs of sexually abused students, and schools can play an essential role in linking a child to services. Many schools have already begun to take positive actions to initiate programs for students who are abusing drugs and alcohol, such as addressing the self-esteem levels of such students so that they can refuse peer pressure. (Generally, students with high self-esteem value themselves and plan positive futures for themselves versus disconnecting from their world by abusing drugs and alcohol.)

One intention of this study was to determine what services existed for survivors of sexual abuse, an abuse which violates far more than a child's physical and sexual boundaries. Sexual abuse vastly affects feelings of self-worth, self-esteem, and boundaries of all types. Typically, children who have been victimized must work for many years to heal issues ranging from fears of abandonment, terror, rage, and all areas of self-esteem. Children who have been sexually abused must be empowered to deal with boundaries and self-worth issues, over and over again. Suicide attempts are possible, and some children do not survive. For example, most children struggle as adolescents and adults with their rights to state what they do and do not want, to receive love and nurturing, to trust, and to set boundaries concerning their emotional energy, time, physical space, and sexual behavior. Many also struggle with continued emotional and physical abuse issues.

Primarily during the 1980s, schools across the U.S. were forced to enter the arena of drug and alcohol abuse education. During the 1990s, they are more and more frequently being required to intervene in another area previously assumed to be a "family affair"--child sexual abuse.

School personnel across the U.S. must become aware that their legal requirement to identify and report child abuse is only the first step in a process. Because the majority of child sexual abuse occurs within the context of the family, identifying the abuse frequently involves overcoming a block of denial in the family system. Whether or not the child is removed from the family and placed in a foster home or elsewhere, the break in family denial or the telling of the secret is both a relief for the child, and an enormous upheaval in the child's (and typically the family's) life. Most children are filled with unexpressed rage, as may be the spouse of a perpetrator. Usually more than one child in a family has been abused, if the perpetrator is a family member, or lives with the family.

School personnel may be expected to discuss a variety of issues for which they have received no training, with parents, foster parents, and/or siblings. Many children begin a journey of living in one foster home after another, while feeling guilty about the abuse and the disruption to the family, experiencing shame and feelings of low self-worth. A child's suppressed self-esteem and other issues may affect school attendance, grades, and other areas of performance. Issues such as possibilities of teenage pregnancy and sexually transmitted diseases may need to be addressed. Teachers generally want to know how best to support the child and still educate other class members.

Table 17 above depicts current services and programs offered by schools, <u>once the abuse has been identified.</u> Please keep in mind that 48.3% of all districts surveyed did not have sexual abuse prevention and treatment programs. Table 17 indicates that the most common services available in districts with programs were drug and alcohol abuse education, education about feelings, student self-esteem enhancement resources, crisis counseling, general school counseling, HIV/AIDS prevention, sex education, identification of feelings, communication skills, social services, and the processing of feelings. It should be noted that a majority of schools have drug and alcohol abuse education, sex education, and general school counseling as part of their general programs available to all students. Many schools incorporate self-esteem enhancement efforts and communication skills into drug and alcohol abuse education and routinely offer social services.

Program components generally available in less than half of the suburban and rural districts with programs but more frequently available in urban districts with programs included peer support systems, strategies to empower students, family education/involvement, teacher support systems, comprehensive health services, case management teams, recreational <u>alternatives</u>, community education, English as a Second Language programs, and multi-cultural education programs. Significant differences, as per a chi square test, between rural and urban responses occurred in the two choices, English as a Second Language and case management teams.

In general, all districts that had programs seemed to recognize the importance of drug and alcohol abuse education, the identification and understanding of feelings, the development of self-esteem, counseling, HIV/AIDS prevention, sex education, and the development of communication skills. To a lesser degree, districts recognized the importance of social services, the processing/expression of repressed feelings, and peer support systems.

Rural and suburban districts lagged in teaching strategies of empowering students, family education/involvement, community education, and the provision of teacher support systems.

To a more serious degree, rural and suburban districts did not fully access the benefits of confidential case management teams. Comprehensive health services and the creation of recreational alternatives generally were not accessed.

Most districts lacked strategies for involving the community in planning efforts. Rural and suburban districts may not have prioritized English as a Second Language and multi-cultural education because their populations tend to be more homogeneous than those of urban districts. Across all types of districts, therapeutic programs that have been found effective (and are even institutionalized in a few states) were generally not provided. These included drama, art therapy, movement/dance education, and music therapy.

Urban districts were more likely to offer education about feelings and identification and processing of feelings. They were also more likely than rural or suburban districts to include the program components of family or community involvement, communication skills, recreational alternatives, drama, movement/dance, art and music therapies, comprehensive health services, sex education, English as a Second Language, multi-cultural education, peer support systems, and case management teams. They were less likely than rural or suburban districts to offer tutoring.

Rural districts were less likely than suburban and urban districts to offer identification of feelings, processing feelings, strategies for empowering students, music therapy, comprehensive health services, sex education, and teacher support services.

Suburban districts were less likely than rural and urban districts to offer vocational education, alcohol and drug abuse education, and comprehensive health services.

In summary, services for which federal or state money is readily available, services for which the need is readily acceptable, and services that previously existed in a district were most frequently available. Examples include drug and alcohol abuse education, counseling services, and self-esteem enhancement activities. Services that were less well known or acceptable, yet are highly effective for sexually abused students (e.g., art therapy to process feelings and movement/dance activities designed to assist the student in re-connecting with her or his body) are generally not available. It appears that this is sometimes because staff who are qualified to deliver such services or state or federal funding supplements are not readily available to financially strapped districts.

COLLABORATION

Respondents were asked which agencies and individuals are actively involved with their district, to encourage the prevention and treatment of child sexual abuse. Table 18 below indicates responses to this question.

Table 18

Collaborative Agencies and Individuals

	Total	Rural	Urban	Suburban
Child Protection/Dept. of Welfare	85.1%	84.9%	88.9%	84.1%
Univ. training programs	9.6%	9.5%	16.7%	6.8%
Community businesses	16.0%	14.3%	33.3%	13.6%
Law enforcement	75.5%	77.8%	83.3%	65.9%
Coop extension	18.6%	27.8%	11.4%	19.8%
Public health	60.1%	60.3%	72.2%	54.5%
Foster care	25.5%	27.8%	27.8%	18.2%
Volunteer agencies	34.0%	27.8%	61.1%	40.9%
Private therapists	31.9%	30.2%	27.8%	38.6%
Substance abuse progms.	55.9%	55.6%	66.7%	52.3%
Community committee	32.4%	31.0%	38.9%	34.1%
Other	20.2%	15.1%	44.4%	25.0%

The above data indicate that, of the 48.3% of all districts with programs, the most commonly involved agencies and positions were those required by federal and state law. This includes state agencies such as child protective services departments and/or departments of public welfare. The vast majority (average 85.1%) of districts used their services, and percentages were relatively consistent across all types of districts.

An average of 75.5% of all districts involved law enforcement agency personnel. This is also consistent with state laws and district training priorities regarding reporting suspected abuse. The vast majority (83.3%) of urban districts reported involving such personnel, versus 65.9% of rural districts.

A clear majority (60.1%) of all districts also involved public health personnel in their programs. Urban districts led, with 72.2%, followed by 60.3% of rural districts, and only 54.5% of suburban districts.

A majority (55.9%) of all districts involved substance abuse programs. Urban districts were most likely to involve them (66.7%).

The involvement of volunteer agencies was generally less frequent, and less evenly distributed. A majority (61.1%) of urban districts versus 40.9% suburban, and 27.8% of rural districts involved volunteer agencies. The chi square tests found a "significant" difference between rural and urban percentages. Urban districts tend

to have more volunteer agencies. Rural citizens also may face barriers of remote locations and transportation difficulties. A previous study also indicated rural citizen are generally reticent to become involved in the volatile area of sexual abuse when it potentially involves neighbors, employers, and friends (Helge, 1991).

One-third (32.4%) of the districts surveyed involved committees of community representatives. Percentages were evenly distributed across the types of districts.

Roughly one-third (31.9%) involved private therapists, as indicated by suburban (38.6%), rural (30.2%), and urban districts (27.8%). It is possible that suburban districts have the greatest accessibility to therapists and/or the most money available to pay them.

Only one-fourth (25.5%) of all districts tended to involve foster care agencies, even though a high percentage of children identified as abused are assigned, at least temporarily, to foster care placements. Rural and urban percentages were equal (27.8%), but only 18.2% of suburban districts reported involvement of foster care agencies.

One-fifth (20.2%) of all districts involved "other community resources." The greatest percentage was reportedly by urban districts (44.4%), and the chi square tests found a "significant" difference between the average percentages of rural, urban, and suburban districts.

An average of 18.6% of all districts involved cooperative extension agency personnel. Because cooperative extension is primarily a rural resource, involvement in rural districts (27.8%) far surpassed that of urban or suburban districts.

Only an average of 16.0% of all districts involved community businesses in their programs. The fact that urban districts (33.3%) most frequently did so, followed by rural (14.3%) and suburban (13.6%) districts, is not surprising. Most businesses are located in cities. Businesses across the U.S. most frequently offer partnership opportunities to urban areas where they typically locate plants, hire employees, and gain visibility for community involvement. Also, urban districts tend to have the best resources (e.g., grantwriting staff and expertise, possibilities for positive public relations opportunities, etc.) for approaching businesses.

Less than ten percent (9.6%) of all districts involved university teacher training programs with their sexual abuse programs. Urban districts (16.7%) again outpaced rural (9.5%) and suburban (6.8%) districts. University programs tend to be accessible to teacher training practicum and other training sites. Urban areas offer large enough university and public school student populations for diverse training opportunities, and less funding is required for transportation of faculty and students to training sites.

In summary, collaboration appeared to be most frequent, with external agencies and individuals related to state and federal legal requirements (e.g., departments of public welfare, child protective service agencies, and law enforcement personnel). There were some complaints that law enforcement officers, public welfare/child

protective service workers were slow to respond or did so "informally." A majority of programs also collaborated with public health personnel and substance abuse programs. Urban areas involved "others" at a rate of 44%.

Less frequently involved resources were volunteer agencies, community citizens, and private therapists. Infrequently involved agencies were foster care agencies, community businesses, and teacher training programs. It appears that greater efforts should be made to involve extra-school resources beyond those required by federal and state law.

LIAISONS BETWEEN SCHOOL DISTRICT AND COMMUNITY SUPPORT SERVICES

Interviewees were asked to name the primary liaisons between the school district and community support services. Respondents could name as many positions as were appropriate. Table 19 below indicates responses to this question.

Table 19
Primary Liaisons Between District and Community Support Services

	Total	Rural	Urban	Suburban
Superintendent	36.0%	42.7%	33.3%	18.2%
Asst. Supt.	19.9%	16.1%	22.2%	29.5%
Principal	60.2%	64.5%	55.6%	50.0%
Teacher	32.8%	33.9%	33.3%	29.5%
Case Mgm. Tm	19.4%	16.9%	33.3%	20.5%
Counselor	72.0%	81.5%	44.4%	56.8%
Spec. Ed. Adm	23.1%	22.6%	22.2%	25.0%
Psych.	31.2%	29.8%	38.9%	31.8%
Nurse	51.6%	51.6%	55.6%	50.0%
Other	12.9%	4.0%	38.9%	27.3%

All types of districts tended to have more than one position as liaison. The "other" category was defined by respondents as including social workers and at-risk coordinators.

Table 20 indicates the positions listed as primary liaisons, in decreasing order, by type of district.

Table 20
Positions Listed as Primary Liaisons (% are in decreasing order)

Total	Rural	Urban	Suburban
Counselor 72%	Counselor 81.5%	Principal 55.6%	Counselor 56.8%
Principal 60.2%	Principal 64.5%	Nurse 55.6%	Principal 50.0%
Nurse 51.6%	Nurse 51.6%	Counselor 44.4%	Nurse 50.0%
Supt. 36.0%	Supt. 42.7%	Psychologist 38.9%	Psych. 31.8%
Teacher 32.8%	Teacher 33.9%	Other 38.9%	Teacher 29.5%
Psych. 31.2%	Psych. 29.8%	Teacher 33.3%	Asst. Supt. 29.5%
Sp. Ed. Ad. 23.1%	Sp. Ed. Ad. 22.6%	Supt. 33.3%	Other 27.3%
Asst. Supt. 19.9%	Case Mgm. 16.9%	Case Mgm. 33.3%	Sp. Ed. Ad. 25.0%
Case Mgm 19.4%	Asst. Supt. 16.1%	Sp. Ed. Ad. 22.2%	Case Mgm. 20.5%
Other 12.9%	Other 4%	Asst. Supt. 22.2%	Supt. 18.2%

All types of districts relied more heavily on building-based and direct service personnel (primarily counselors, principals, and nurses) than on central administrators (superintendents; assistant superintendents) to serve as liaisons with community sources.

Rural districts were far more likely (81.5%) than urban (44.4%) and suburban (56.8%) districts to involve counselors and also more likely to involve building principals (64.5% rural versus 55.6% urban and 50.0% suburban districts). Rural districts were also most likely to involve superintendents (42.7% rural versus 22.2% urban and 18.2% suburban). Rural districts were less likely to involve psychologists (29.8% rural versus 38.9% urban and 31.8% suburban). Case management teams were more likely to be involved as liaisons in urban districts (33.3%) versus suburban (20.5%) or rural (16.9%) districts. The "other" category of social workers and at-risk coordinators was most frequently listed by urban (38.9%) and suburban (27.3%) districts and was only mentioned by rural districts by 4.0% of all respondents. Lesser involvement of psychologists and case management teams and "others," (primarily social workers and at-risk coordinators) is consistent with previous findings that urban districts are far more likely to employ psychologists, social workers, and at-risk coordinators and to use a case management team approach. Counselors in rural districts tend to have generic job responsibilities. (Studies have, in fact, found that they are expected to "be all things to all people.")

Approximately one-third of all respondents (from 29.5% to 33.9%) reported teachers as liaisons. Almost one-fourth (from 22.2% to 25.0%) of all respondents cited special education administrators as liaisons.

Rural district respondents (42.7%) were more likely than urban (33.3%) and suburban (18.2%) interviewees to cite superintendents as primary liaisons. According to an analysis of variance test to assess significance of group

differences, "significant" differences occurred in rural versus suburban respondents' citing of superintendents. "Highly significant" differences were indicated in rural versus urban and in rural versus suburban respondents' listing of counselors. Regarding "other," rural versus urban and rural versus suburban differences were "highly significant."

STRATEGIES DISTRICTS FEEL ARE EFFECTIVE

This section of the report cites anecdotes by respondents, when asked to identify effective strategies. The reader will quickly note that many respondents focused on their concerns, frustrations, and problems, versus having "effective strategies" to report.

Respondents were asked the most effective strategies their districts used to assist students at-risk for sexual abuse or students identified as having been abused. At this point, a number of districts stated that their programs were under development and that they had no effective strategies to share due to a lack of experience or due to their program being too new to evaluate. Some reported that their programs had been implemented in too big a hurry, to meet a state mandate. Staffing and inservice training were mentioned as problems in such programs. For example, some staff were unwilling to work in the programs due to the fact that their attitudes had not been dealt with before the program was begun. Time constraints were mentioned as an additional problem.

A number of districts mentioned that once abuse was reported, the appropriate agencies did not act. This lack of community and state agency support was very frustrating for staff. Some districts reported that the most frequent response by outside agencies was "there is nothing we can do."

Others reported that families in denial were a stumbling block and that people did not want to talk about the problem that existed. Some reported a backlash from staff and/or community personnel based on the attitude that schools are supposed to teach children and not solve students' problems. Some district respondents reported that children who told of their abuse were not believed. Some reported "the community just wants the problem to go away" or "the community will not acknowledge that there is a problem here." Statements such as, "we don't need a program until we see abuse," were alarming.

Too frequently, there was an assumption that district child abuse prevention curriculum could be adequately covered by "including" it as part of a four to eight hour unit on drug education. Some districts referred children having inappropriate behaviors to their school-based student assistance teams and asked them to assess the information. According to most state regulations, child abuse should be reported directly by the individual noting the abuse to the proper legal authorities. A number of schools were instead, referring abuse to something like a student assistance team. Some were telling principals instead of legal authorities and assuming that the principals would tell the appropriate authorities. Some personnel in districts have been sued for not reporting abuse directly to legal authorities.

District personnel generally appeared to feel that their responsibility ended when referrals were made to legal authorities. There was an assumption that the child's problem had then been resolved.

Some districts reported that teacher training involved giving each teacher a booklet each year and asking them to read it. Other paraphrased comments include, "this is a good church going community. Residents are born here, live here, and die here. All those problems we read about in the newspaper happen other places, not here... However, I can't figure out our teenage pregnancy problem. Kids aren't learning 'that stuff' (sex) from parents, so we don't know where they're learning it."

The most successful approaches that were reported emphasized prevention. These approaches included teaching awareness of appropriate and inappropriate touch and teaching empowerment skills (refusal skills, self-esteem development, protective behaviors, etc.). Children were taught to tell a responsible adult about inappropriate behavior (including comments and touching) and were told that if that adult did not believe them or did not act, that they should tell another adult and continue to do this until they got assistance. This is essential because many adults do not believe children who talk about their abuse. Some adults have reasons not to want to hear that abuse is occurring in their own family.

Most prevention programs emphasized making children aware of what is and what is not okay, where and how to report abuse, and where help can be found. This continuous emphasis on resources available appeared to be essential to an effective program. It is necessary for teaching to be frequent, continuous, and involve open discussions in one on one and/or small group, supportive situations. Children must establish a connection with teachers who are comfortable with the topic of sexual abuse. Interagency collaboration is essential regarding awareness of the problem, among children, schools, and community members. It is important that preventive efforts start at kindergarten or below. The Kids on the Block puppet system has been used by some schools to teach sexual abuse curriculum, in a dynamic way.

Children were taught to be aware of resources and to understand the acceptability of getting help. Their rights to receive assistance and their needs for it were emphasized. Many children do not know that they are being abused because (particularly if it is a family affair) "this is all the children know and they assume that's what love is, or that this is the way that all children are treated." Children in such families need to be taught how to know if they are being abused and how to report their abuse to a responsible adult.

Self and peer referral are emphasized in successful programs. Awareness presentations are helpful. For example, one district does a program based on a play, "No More Secrets." This is a dynamic drama in which children in the audience interact. The perpetrator is shown as a charming person who willingly involves himself with children in the community. He then gradually begins to molest a child and stresses that no one will believe her if she tells, that she will get in trouble, and that something horrible will happen to her. (By now she has developed a bond with him.) A peer of the child who is being molested finally convinces the child to tell what is happening so that the perpetrator "can get help." She stresses that if her

friend does not tell, she will. This particular play stresses over and over, with audience interaction, that it was not the child's fault, and that the child must tell the secret so that she can get assistance and so that the perpetrator can be stopped from hurting other children.

The next most frequently mentioned strategy felt to be successful, included a case management team in which it was assumed that confidential information must be held confidential, other than for reporting and other legal actions. It was felt that intervention must be immediate and responsive. A variety of personnel must be involved within the school system and with affiliated agencies. The interagency collaboration should involve relevant teaching, administrative, counseling, nursing, social work, and outside agency personnel such as children's services, alcohol abuse, social service, counseling, literacy, mental health, and other health and human services personnel, including private therapists. Individual and group counseling should be available to the student, again, on an immediate and responsive basis. Children and counselors must be comfortable discussing issues.

Children must be removed immediately from any dangerous situations. This must be done by authorities, and they should be cognizant that when one child is removed, if a perpetrator stays in the home, typically the abuse then centers on another child.

Some districts had an objective to maintain a child in the home environment, and some stated that they wanted to make sure that the child was able to get out of the abusive home environment. This is a controversial issue. In one state (Washington), the state administrative code stresses removal of the perpetrator, versus the child, from the home. However, in most states, it is assumed that the perpetrator will stay in the home, at least until due process has determined that this individual should be jailed. Thus, most authorities believe that a child must be taken from the home, particularly if the spouse is in denial, and the perpetrator is a parent, step-parent, or boy- or girlfriend.

A situation that has been overlooked once is likely to be overlooked again. Additionally, it is difficult for children to heal in a situation where they face their perpetrator on a daily basis. It is difficult for investigators to have the funds for staffing to adequately monitor such a situation and for children to develop trust that the process is really one that is centered around their healing experience. Yet, placing an innocent child in foster care, at a time when they are experiencing a great deal of pain is traumatic. Foster care parents are, unfortunately, not always adequately screened or trained. Many abused children are re-abused in foster care settings.

A few districts mentioned that their "only strategy" is continued contact with the school counselor. Many counselors do not have time to work with the students on the basis that is required for healing sexual abuse. Children's feelings and the dynamics of the dysfunctional family must be dealt with.

Follow-up was essential after the referral agency such as the Department of Public Welfare evaluated the home situation. In general, districts with successful

programs address the importance of nonjudgmental intervention that is responsive, and has thorough follow-up. They emphasize the importance of a high profile so that the community knows that this is a serious effort on the part of the schools to stop the problem and that child abuse will not be tolerated.

Some districts describing effective programs mentioned that relationships were developed with the students and a special counselor (this could be from an interagency collaboration agreement in which the counselor had more time than a school counselor). For example, some Catholic Community Services agencies followed children throughout their entire school careers, involving them first in off-campus programs several days a week and later in discussion groups of peers, as the children became teenagers. They also worked with family members when this was possible. Most of the effective programs seemed to approve of family counseling but recognized that the child needed special counseling that was totally devoted to his or her healing versus attempting to heal a wound as large as sexual abuse, in a family therapy setting.

Support groups such as peer support systems (Natural Helpers, etc.) appeared to be helpful when confidentiality was not a factor and when the students were well trained. Some districts mentioned one-on-one district wide "special contact" counseling.

Teacher education was seen as a necessity by all who talked about effective programs. Teachers need to be made aware of and sensitive to, not only behaviors to watch for in children and families, how to report abuse and where resources are, but how they can assist with the child's healing process and still fulfill their other classroom responsibilities. Teachers need to learn to discuss feelings and to understand dysfunctional family dynamics. They need to understand ways that they can be supportive of children without ostracizing them, and how to maintain confidentiality.

Teachers in successful programs were taught to conduct confidential observations and be aware of changes in children's behaviors and other signs to look for. They were taught how to support children and how to report abuse. They were made comfortable with the issues and topics related to sexual abuse of children. They were taught how to create and reinforce open communication about "anything." They were taught how to be part of a successful follow-up program whether or not family members are responsive to a child's problems. They were taught the importance of nonjudgmental responsiveness and follow-up.

Many districts reported that they dealt with sexual abuse curriculum as part of health education. Other districts say that they incorporate sexual abuse prevention and treatment into AIDS/HIV education and prevention programs. AIDS/HIV education and prevention programs are typically oriented toward helping children understand that they must take responsibility for safe(r) sex or abstinence. A child who is being abused is not given a choice. In addition, many AIDS/HIV education programs are not initiated until children are in middle school.

One K-12 curriculum that was described involves building self-esteem. The program is designed so children know how to receive help and deal with problems that they may experience. The concept is based upon the idea that a child must feel good about him or her self in order to deal with life. Another program involves a cross-curriculum approach. The program teaches decision-making, making choices and accepting consequences, safety and refusal skills, assertiveness, and age-appropriate substance abuse curriculum. It is not specifically a sexual abuse prevention and treatment curriculum.

Some districts that anticipated resistance to their sexual abuse prevention and treatment programs involved religious groups early in program planning so that they would gain their support. By fully informing such groups, and explaining to them how widespread the problem is, they were able to build support, change attitudes, and gain valuable community resources.

Comprehensive programming is essential. Some districts conduct special programs three to five days per year and integrate sexual abuse prevention and treatment across health and other classes during the year. The more frequently students understand what sexual abuse is, get the message that it is "not okay," and that they must report it and get help, the more likely students are to come forward with their problem.

One district reported, "We are a rural small school, our staff know the families well, and the families know the staff well." This can be a problem if school and community personnel attempt to solve problems informally. For example, a teacher might report abuse to the principal, versus to legal authorities. The principal might decide to talk to the abuser personally and tell him to "watch it." This informal versus legal way of handling the problem may mean that the child does not receive assistance. Instead, the child may receive a backlash from reporting the abuse. The abuser simply may become more careful. Finkelhor and Williams (1992) found that offenders are generally charming, and very careful to cover their actions. They usually victimize children over and over again, and do not exhibit any ability to feel compassion or remorse for their victim(s).

One district reported a community outreach prevention education program that uses the school as the primary location of its program. It involves a school-based clinic staffed by counseling interns who are supervised by mental health services personnel. If offers support services and therapies for families at-risk. This approach is important in that it is critical that we empower the families so that the perpetrator does not need to abuse the child.

One district reported a comprehensive program including group and individual counseling in which children dealt with their anger. They became aware that they are not alone, and that other children have been abused. Personnel constantly stressed that the abuse was not the child's fault. Children were taught to assertively say "no." They also developed goals, and wrote to their abusers. Art therapy is used as well as role playing, psychodrama, and stress management. Prevention activities include developing awareness of how abusers operate.

Other findings include the fact that this is a new priority of schools because families are frequently feeding the problem (i.e., most perpetrators live in the home). Leadership from schools is desperately needed. School personnel must become aware that families are frequently consisting of boy- and girlfriends, step-parents, and extended family members. Neighbors and baby-sitters are frequently involved in abuse. Some perpetrators share pornography with children and gradually work into molestation. Satanic abuse is becoming more frequent as are other forms of ritualistic abuse.

LIMITATIONS OF THE STUDY

This was a random stratified sample that was descriptive in nature. It was designed to be accurate with an 8% margin of error, if over 200 districts were involved. A total of 211 districts were involved. A total of four states were not involved in the sample due to random sampling (Alaska, Kansas, Maine, and North Dakota). Delaware and Rhode Island were not involved because their districts did not respond.

This descriptive study reports respondents' perceptions of their districts' child sexual abuse prevention and treatment programs. When respondents appeared to be confused regarding their state mandates, investigators secured and examined all states' administrative codes.

Beginning with question #3 (see Appendix A for survey), only districts were surveyed that stated that they have a sexual abuse program. As the questions became more specific, some admitted at that point that they did not really have a program. Thus, the study may err on the side of believing that respondent statements that programs existed that do not.

If our schools and the larger society handle our current child sexual abuse problems effectively, the next generation of students will be healthier and will produce more loving families, with children who are able to learn and to be productive citizens. If not, we will produce another generation of social problems related to sexual abuse, composed of adolescents and adults poorly equipped to be parents and productive citizens.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Extent and Implications of the Problem

This study was designed to determine trends in child sexual abuse prevention and treatment services, offered by school districts across America. The questionnaire was designed to allow comparisons of urban, rural, and suburban school district programs and to determine gaps in services.

Even though accurate statistics regarding sexual abuse of children and adults are quite difficult to obtain, it is obvious that the rate of sexual abuse of children and adults in our society is appalling, and growing rapidly. Several national organizations and studies have estimated that one out of three girls and one out of four or five boys experience sexual abuse by the age of 18. Sexual abuse occurs in all racial, ethnic, class, geographic, and cultural groups.

Our society is beginning to be aware of, and to accept ownership for, child abuse. Yet, in general, children are not sufficiently protected and some of the primary professions that could and should be most aligned with children's rights have been slow to respond. These include the medical profession and the field of education. The media are beginning to be more factual in presentations of child sexual abuse and to more frequently advocate that stronger actions be taken to protect children. Yet, social and gender inequality and cultural support of violence (causes of family violence) are still promulgated by the media.

Child sexual abuse is not about sexual intimacy. It is about the exercise of power and control. It involves the physical violation of a child's body through sexual contact or stimulation, the violation of the child's personal and psychological boundary through intrusive sexual contact. Thus, sexual abuse is a crime of violence.

Children raised in abusive environments are at high risk for physical and emotional health problems, developmental delays, self-esteem difficulties, and school-related problems. Child sexual abuse is related to all major social problems. These include domestic violence, runaway children, mental illness, crime, drug and alcohol abuse, dysfunctional families, HIV and other sexually transmitted diseases, teen pregnancy, prostitution, school dropouts, low self-esteem, homelessness, sexual dysfunction, certain physical problems, anorexia-bulimia, violence, and pornography.

Children who have experienced violence and exploitation may enter adulthood without the skills or motivation to contribute to society. Because they may be poorly equipped to reap the benefits or meet the responsibilities of parenthood, citizenship, and employment, the consequences of their problems frequently reach far beyond their personal lives. National studies have indicated that 80 to 90% of inmates in prisons were abused as children. Studies have also indicated that as many as 99 to 100% of youth who engage in survival sex (e.g., prostitution) have been sexually abused.

On the other hand, many children who have been sexually abused cope very well and exhibit their problems with self-esteem by becoming overachievers, "people pleasers," and persons who feel that their worth is based on their ability to achieve in various ways. They are adept at meeting the needs of others. However, they usually are unaware of their own needs, and do not meet them. Although this behavior may, at least in the short term, produce very few overt problems for society, such a condition may be considered a "ticking time bomb" in that repressed memories of sexual abuse will at some point be triggered. Typically, a person who has been abused and has repressed their memories retrieves those memories during their 30s or 40s. At the least, by that time, they have suffered

difficulties with relationship and self-esteem issues for a large percentage of their lifetime.

In 80% of all cases of sexual abuse, the offender is known to the child. Children are most frequently victimized by their caretakers, usually family members. Child abuse, in general, has been strongly linked to domestic violence. Social and gender inequality and cultural support of violence are underlying causes of family violence. It is interesting that cultural support of violence and social and gender inequity cause violence. Yet, gender inequity is also symptomatic of violence in our society.

Increasing numbers of children are running away from family conflict and sexual abuse as well as other violence. Such children are in great danger of homelessness and of additional sexual and physical abuse while "on the road." Many (particularly illegal aliens and minority migrant children) face language, bicultural, and legal barriers.

America's Children Are Not Protected

America's children are not adequately protected by state or federal regulations. Au contraire, the 1974 Child Abuse Prevention and Treatment Act (P.L. 93-247), established a National Center on Child Abuse and Neglect to gather data, provide for demonstration grants and technical assistance, conduct and publish research regarding causes and incidence of child abuse and neglect, develop and maintain an information clearinghouse on successful programs, and compile and publish training materials for personnel in the field of child abuse and neglect. The law states that in order for a state to qualify for assistance, the state must have in effect a state child abuse and neglect law that provides for the reporting of abuse and neglect, and for other provisions such as follow-up investigations. Thus, each state must have some kind of reporting procedure, provisions for follow-up investigations, personnel trained in child abuse and neglect prevention and treatment, and training procedures. As how to accomplish this is expressly up to each state to mandate and each area within a state to enforce, numerous problems arise.

State "mandates" vary tremendously, with most states merely "encouraging" school district behaviors necessary to ensure child protection. An analysis of state administrative codes, secured from the National Clearinghouse on Child Abuse and Neglect Information, indicated that "any person with reason to believe that child abuse has occurred must report" in 12 states. Most states mandate that personnel in the fields of health, education, social work, and law enforcement must report abuse to legal authorities. Penalties for not reporting range from a $0 fine for a misdemeanor, up to a $5,000 fine, and/or up to 90 days imprisonment for a gross misdemeanor.

Specifically regarding "education and training" excerpts related to school district responsibilities, 24% of the states (12 states) have no such excerpt. School districts are at least "encouraged" to have child abuse programs in seven states (14%), and districts are mandated to train educators regarding how to report abuse in 12 states (24%). Training is not required to receive teacher certification, except

in three states. These "requirements" (most frequently they are "encouragements") are usually related to the global area of child abuse and neglect. The focus is on reporting, and not on providing follow-through services or adequate teacher education so that teachers know how to help a child who has been identified, even though the child who has been abused must continue to attempt to receive an education.

Thus, the rights of children are really dependent upon the strength of state mandates. Some state administrative codes have knowledgeable, caring language (e.g., California regulations state that schools are the best place to deal with child sexual abuse issues, which usually occur in the home), yet the majority of these state regulations are mired in language which undermines enforcement, while "encouraging" teacher training or community education. Most "mandates" are not well enforced. They may deal with legal liabilities about reporting but require only one hour of training regarding all areas of child abuse. They may allow a district to hand each teacher a brochure which may or may not be read, and to assume that teachers will report abuse. According to district respondents, local child protective service workers and law enforcement agencies frequently do not follow up regarding reports of abuse. Teachers are frequently "reporting" to persons other than legal authorities, and sometimes these individuals choose to "handle the situation informally."

Most state incest laws were originated to legally outline persons within families who were ineligible to marry. The narrow legal definitions of incest, together with stringent requirements for proof of occurrence, are coupled with generally meager punishments for offenders, and the trauma of victims who must testify. All of these factors tend to make the criminal prosecution of incest a doubtful and sometimes impossible enterprise (Vanderbilt, 1992).

In most cases, for example, criminal prosecution for incest can be undertaken only if the victim is a minor at the time the abuse is discovered. Yet, most frequently, incest does not come to light until the victim reaches adulthood and begins to remember what happened. By then, in most states, the statute of limitations on criminal offenses has usually long since expired. In half of all of the states, vaginal penetration is necessary in order for incest to have occurred. This means that males, by definition, never experience incest. In four states, the corroboration of an independent party is required, at least to some degree. This is highly unrealistic as most perpetrators force their victims to keep incest a well kept secret (Vanderbilt, 1992). Statutes of limitations generally are reckoned from the date of injury and run for a fixed period, often three years. In some states, the statutes begin when the victim remembers the abuse. The phenomenon has been called "delayed discovery" and is based on the fact that someone who has no memory of an act cannot complain about it (Vanderbilt, 1992).

Most state "mandates" and incest laws should be updated. Enforcement of laws and mandates should be methodical and consistent. Neglect and emotional abuse issues are very difficult to prove. Many foster care children are re-abused. Screening and training procedures for foster parents, appear to be inadequate.

Many children are abused while visiting non-custodial parents. Parental visitations may not be prohibited until evidence can be gathered, which small children lacking comprehension and language skills cannot provide. Yet, the children scream when it is time to visit the non-custodial parent, and experience nightmares and other pain in between visits.

Regarding the School's Responsibility

It is simply not an option for school and other personnel to comment that "child sexual abuse is not the school's responsibility" or "it doesn't happen here." Data dispute the contention that child sexual abuse is not occurring in communities all across America.

Regarding the school's responsibility, as sexual abuse is primarily a "family affair" (whether it is in the immediate or the extended family), schools must begin now to play the active role that a majority of school districts have assumed regarding the prevention of alcohol and drug abuse.

Children who are in emotional pain do not learn effectively and cannot fulfill their potential for themselves or for society. Children who have been abused contain unexpressed rage in their bodies. This rage will eventually be expressed. It may be turned inward (e.g., suicide, self mutilation, anorexia-bulimia). It may be expressed violently (crime, becoming a perpetrator). The effects of abuse may be expressed through drug and alcohol abuse or teen pregnancy. Any of these effects have implications for America's classrooms. Thus, we have no choice but to make the schools' roles in the prevention and treatment of child sexual abuse, a priority.

Childhood sexual abuse predisposes some victims to participation in a number of high-risk adolescent behaviors regarding HIV infection (e.g., sexual promiscuity and chemical dependency). Sexual abuse may be the sentinel event in the lives of HIV positive adolescents. Thorough pursuit of sexual abuse is essential for the basic survival of our society. Discovery of this underreported victimization of children can allow the process of intervention to begin.

Social denial must be replaced with an understanding that one-third of all girls are sexually abused by age 18 and one out of every four or five boys is also abused by age 18. With the right strategies, the pubic will respond. A study conducted by the National Committee for the Prevention of Child Abuse found that over 90% of the public agreed that all elementary schools should offer instruction that teaches children to protect themselves from child abuse, especially sexual abuse. In addition, 64% of all Americans were found to think that they can personally help prevent child abuse (National Committee for the Prevention of Child Abuse, 1992; American Humane Association, 1988).

Key Findings of the Study

The percentages of districts in this study were representative of rural, urban, and suburban districts across America. The random sample consisted of 211 districts completing phone interview questionnaires. Persons completing the questionnaires were designated as at-risk student program coordinators or their equivalent, by the districts.

In spite of the fact that one in three girls and one in four or five boys are sexually abused by age 18, 51.7% of the surveyed districts did not have prevention and treatment programs. Findings indicate that the districts tend to at least tell staff to report abuse, but do not adequately train them regarding how to prevent and treat child sexual abuse. Follow-up tends to be highly inadequate, as does support for students.

Even though stopping child abuse requires the involvement of the entire community, citizens of the community were seldom involved in training. (State administrative codes legislating "appropriate public awareness" represented 18% (9) of the states with four of those states including a "within available funds" clause.) The target population regarding preventing child sexual abuse (students) were only reported as receiving training by 43.8% urban, 54.2% rural, and 63.7% of the suburban districts that related having programs. Many districts reported that training was not needed because "sexual abuse is not a problem in our district."

Direct service personnel and administrators at the building level were most frequently involved in planning and implementation of district sexual abuse programs. Such personnel involved principals, teachers, counselors, and nurses. A majority of urban districts with sexual abuse programs also involved social workers and school psychologists. Urban districts involved the highest percentages of most personnel and were most likely to have a formal case management team including an at-risk coordinator. Suburban and rural districts seldom employed a formal case management team. Yet, in the section asking respondents to name their most successful strategies, case management teams were mentioned as one of the most effective strategies for assisting students in their healing.

District respondents were also asked to estimate the amount of time that their prevention and treatment programs were offered. Comments indicated that sexual abuse prevention and treatment programs typically were offered in only one grade. Frequently, it was only via one assembly during one grade level. Generally, this was oriented solely toward topics like "good touch--bad touch," versus a comprehensive program. An assembly once a year or a program in one grade level once a year does not give the type of support that children who are being abused (particularly if it is occurring in the home environment) need to be able to summon the courage to say no and to trust an adult authority figure to tell them that abuse (for which they are typically being told that they are responsible) is occurring.

Suburban districts and urban programs were perceived to be more fully supported by the community, than were rural programs. This is consistent with findings from other studies, that controversial or nontraditional efforts, such as sex education, are

generally not as well received in rural as in nonrural districts. Other studies have also indicated that rural schools have higher percentages of at-risk children including sexually active children, victims of child abuse, substance abusers, and children experiencing suicide attempts and depression. Clearly, additional efforts are required to educate rural and other communities about the extent of child sexual abuse and the need for prevention and treatment efforts.

Interviewees were also queried regarding the comfort level of staff teaching curriculum regarding sexual abuse. In urban districts, the vast majority of the respondents stated that staff were "very comfortable." Almost half of the rural and suburban respondents stated that their staff were only "moderately comfortable." Personnel in sexual abuse prevention and treatment programs must be comfortable discussing sexual and abuse issues or students will not divulge abuse or receive assistance. Staff development is needed, and community education is essential.

Regarding the foci of district programs, generally, districts that have programs emphasize reporting and refusal skills. While it is appropriate to have an emphasis on identification of students who have been abused, identification is only the first of many steps involved in helping children heal from sexual abuse. Treatment and other follow-up efforts definitely appeared to be inadequate.

Although it is essential to teach refusal skills and to emphasize prevention of sexual abuse, a more realistic approach to sexual abuse is essential. Teaching refusal skills is necessary on an ongoing basis, to prevent or identify abuse. Teaching children the right to refuse abuse, once a year or only in some grades, particularly if teachers are not very comfortable with discussing sexual abuse issues, will have few results. Most children require consistency and repetition to assimilate new knowledge or skills. This is particularly true when the subject is sexual abuse by a person who has power over the child. As the child's trust of adults has been broken by the perpetrator, it is very difficult for the child to trust that another adult will believe and/or help her.

Many school planning committees have assumed that teaching children to "just say no" to sexual abuse would solve the problem. Some school personnel have stated that parents should teach children how to prevent abuse or should stop abuse, if it occurs. Sexual abuse is about power and violence. It is not about sexual intimacy. Frequently, perpetrators are family members with power over dependent children. Studies have indicated that perpetrators successfully groom family and friends to believe in their innocence. The children typically are confused and have been made to feel guilty about being abused by a person upon whom they are dependent and have little, if any, power to "say no."

School and community members must be made aware of the above factors involved in abuse and design realistic programs. Children need to be encouraged to tell another adult, if the first adult they tell is unable to act or chooses not to. They must be consistently reminded that the abuse was not their fault. Those who are being hurt, those who fear that they will not be heard, and those feeling the depths of their shame, frequently experience suicidal thoughts. At the least, they cannot

learn as well as they would otherwise. For such reasons, a strong treatment (follow-up) program is essential for children whose abuse is identified.

The topics of how to identify and report abuse appeared to be covered by most inservice programs in some fashion. It is important to note that these are not prevention or treatment themes. These themes are related to meeting legal requirements of school personnel, according to state or other guidelines. Thus, although school personnel reported an emphasis on prevention, in actuality, their programs focused on legal requirements. Less than half of all districts dealt with prevention techniques including planning, involving community personnel, conducting community education, and parent involvement.

The study results regarding inservice topics are consistent with more conventional roles of schools to meet legal requirements versus directly addressing social issues. It appears that the "new" roles of schools (e.g., intervention in "family problems" so that children can be given their inalienable Constitutional rights) are not yet apparent in the priorities of school inservice programs.

Interviewees were also asked what procedures were available to support staff who experienced difficulty when sexual abuse issues were discussed. It is extremely difficult for teachers who have not confronted their own pain about sexual abuse to comfortably and effectively assist students. School officials, when presenting inservice sessions regarding child abuse, sometimes find that many teachers are uncomfortable discussing this topic. Some districts have access to state or locally funded employee assistance programs that offer a certain number of free counseling sessions to school employees, with the promise of confidentiality. Some refer to community mental health services, generally available at some fee, perhaps on a sliding-scale basis.

About half of the respondents reported that their districts refer employees to counseling services, and almost half offered counseling. Districts offering counseling in-house face a variety of issues. It was anecdotally reported that sometimes "counseling" merely involved a discussion concerning an employee's belief system that the district should not be involved in sexual abuse prevention and treatment or that the individual did not choose to be involved. Because "counseling" by definition offers confidentiality to a client, it is generally difficult to justify counseling for a district employee within the school district setting. Lack of confidentiality and concern for job security are only two factors involved. Many districts indicated that a teacher having difficulty discussing sexual abuse would be sent to talk to the school superintendent or principal. Some respondents reported that sexual abuse survivors experiencing difficulty when sexual abuse issues were discussed were referred to a district "debriefing" or crisis intervention team, a student assistance team, district social worker, or counselor. Typically, employees who are adult survivors of sexual abuse and have not previously dealt with their pain will feel quite uncomfortable talking to a school district group of peers or to a peer staff member, much less to a supervisor such as a superintendent or principal.

Of particular importance regarding this question, one-fourth of the respondents reported that their district had "no procedures" for supporting staff who had

difficulty with sexual abuse issues. Staff who are uncomfortable and have not received support will experience difficulty assisting children. Children learn from adults, primarily as role models, and not from the words adults say. Children make decisions based on their feelings, much more than on the facts they are told. If they are expected to divulge and be vulnerable enough to heal, we owe them the availability of staff who are comfortable and capable of assisting them. Thus, this issue must be addressed in the context of increased school roles and decreased budgetary resources.

Respondents were also asked if parents were allowed to excuse their children from sex abuse education programs. The vast majority of the respondents (86.0% rural, 81.2% urban, and 82.9% suburban) indicated that parents may excuse their children from activities regarding sexual abuse education. As most sexual abuse occurs within the nuclear family and most victims are told not to tell the "secret," the implications of allowing parents to control the child's sources of information and assistance are obvious.

Interviewees were also asked how frequently their programs were evaluated. Of the 48.3% of the districts having programs, 40.0% of urban, 39.4% of rural, and 35.0% of suburban districts do not evaluate their programs. Furthermore, 26.7% of urban, 20.0% of suburban, and 19.3% of rural programs evaluate their programs less than once a year. An average of 39.6% of the respondents evaluate their programs once a year.

Evaluation that occurs less than once per year provides little useful information for timely restructuring (e.g., change of approaches, incorporation of new knowledge, etc.). Program evaluation does not appear to be a priority of district programs.

Respondents were also asked to specify the components of their district's programs. Program components about which interviewees were queried were selected after research regarding what services are recommended for healing from sexual abuse. A variety of well-rounded options should exist for the academic, emotional, and physical needs of students who have been sexually abused. Schools can play an essential role in linking a child to services. Many schools have already begun to take positive actions to initiate programs for students who are abusing drugs and alcohol and for those who are at high risk of doing so.

Components of effective district programs about which respondents were queried included the following:

Prevention (awareness, refusal skills, etc.)
Early identification
Teacher training
Crisis counseling
Self-esteem development
Education about feelings
Identification of feelings
Processing of feelings
Tutoring
Counseling
Empowering students
Communication skills
Recreational alternatives
Drama
Movement/Dance
Art therapy
Music therapy
Comprehensive health services
Sex education
Drug and alcohol abuse education

Vocational education
Social services
Family education/involvement
Community education
Community education
HIV/AIDS education
Committee representatives involved in planning
English as a Second Language Program
Multicultural education
Peer support system
Teacher support system
Case management teams
Program evaluation

In general, services for which federal or state money is readily available, services for which the need is readily acceptable, and services that previously existed in a district, were most frequently available. Examples include drug and alcohol abuse education, counseling services, and self-esteem enhancement activities related to drug and alcohol abuse education. Services that are less well known, yet have been found highly effective for sexually abused students (e.g., art therapy, drama, or music therapy to process feelings; movement/dance activities designed to assist the student in reconnecting with his or her body) are generally not available. It appears that this is sometimes because staff who are qualified to deliver such services are not available. Sometimes state or federal funding supplements are not accessible.

Respondents were asked which agencies and individuals are actively involved with their district, to encourage the prevention and treatment of child sexual abuse. Collaboration appeared to be the most frequent with external agencies and individuals related to state and federal legal requirements (e.g., departments of public welfare, child protective service agencies, and law enforcement personnel). There were some complaints that law enforcement officers and public welfare/child protective service workers were slow to respond or did so "informally." A majority of programs also collaborated with public health personnel and substance abuse programs.

Less frequently involved resources were volunteer agencies, community citizens, and private therapists. However, to a statistically significant degree, urban districts involved volunteer agencies to a much greater degree than did rural districts .

Infrequently involved agencies were foster care agencies, community businesses, and teacher training programs. It appears that greater efforts should be made to involve extra-school resources beyond those required by federal and state laws.

Respondents were asked who were the primary liaisons between the school district and community support services. All types of districts relied more heavily on building-based and direct service personnel (primarily counselors, principals, and nurses) than on central administrators (superintendents; assistant superintendents) to serve as liaisons with community resources. Rural districts were far more likely than urban and suburban districts to involve counselors and also more likely to involve building principals. Rural districts were also more likely to involve superintendents and less likely to involve psychologists. Case management teams were more likely to be involved as liaisons in urban districts, versus suburban or

rural districts. These data are consistent with those of previous studies indicating that urban districts are far more likely to employ psychologists, social workers, and at-risk student coordinators and to use a case management team approach. Counselors in rural districts tend to have generic responsibilities.

Districts were asked what strategies they felt were most effective. Responses indicated that collaboration should occur between schools and law enforcement, relevant social agencies, universities, businesses, justice systems, employment trainers, JTPA, cooperative extension, child protective service agencies, public health systems other medical personnel, alcohol abuse, mental health and foster care personnel, private therapists, volunteer agencies, HIV/AIDS education programs, parents, and community citizens.

Responses indicated that representatives of the following should be involved in school policy development and program planning: school administrators, educators (general and special education), counselors, social workers, psychologists, nurses, and any special at-risk team assistant in that district (e.g., an at-risk program coordinator or a case management team.) Many rural districts do not employ some of these personnel, due to budget constraints. Respondents stated that interagency collaboration should be <u>active</u> and not merely a passive, bureaucratic process. Respondents felt that all prevention, early identification, and treatment efforts should involve as many of the above groups as feasible.

Respondents reported that inservice and preservice education should include the topics of problem recognition; confidentiality; identification of at-risk families; program planning with community involvement; parental rapport/involvement techniques; secondary versus primary disabilities; development of relevant school policies (with community participation); resources available for prevention and treatment; methods to develop self-esteem of students and parents regarding prevention and intervention; academic assistance programs and techniques; and interdisciplinary, holistic intervention approaches. Training should be comprehensive and should be evaluated.

<u>Children Who Have Been POW's Must Undergo a Healing Process</u>

Sexual abuse vastly affects feelings of self-worth and self-esteem. Typically, children who have been victimized must work for many years to heal issues ranging from fears of abandonment, terror, rage, and <u>all</u> areas of their self-image. For example, most children struggle as adolescents and adults with their rights to state what they do and do not want, to receive love and nurturing, to trust, and to set boundaries concerning their emotional energy, time, physical space, sexual behavior, etc. Many also struggle with continued emotional and physical abuse issues, over and over again. Suicide attempts are possible.

Many children begin a journey of living in one foster home after another, while feeling guilty about the abuse and the disruption to their family when it was discovered. They experience shame and feelings of low self-worth. A child's suppressed self-esteem and other issues may affect school attendance, grades, and

other areas of performance. Issues such as possibilities of teenage pregnancy and sexually transmitted diseases may need to be addressed.

Sexual abuse is related to low self-esteem; feelings of rage, isolation, hurt, rejection, and abandonment; lack of trust; inability to set boundaries; repeated victimization behavior; drug and alcohol abuse; sexually transmitted diseases; suicide; date rape; prostitution; violence; anorexia-bulimia; and suppressed rage that feeds violence and child abuse. The inequities of our society, including those of gender and economics, foster abuse just as does the cultural support of violence, pornography, and denial. Sexual abuse is both a result and a cause of such factors.

Child molestation and incest cause a post-traumatic stress in which those victimized experience the same reactions as do prisoners of war. The ongoing problem that results is a fixed set of learned behaviors (e.g., accepting the role of victim, inability to stand up for one's self, feelings of helplessness, and inability to flee from terror). Most of these learned behaviors must be changed within relationships, as patterns of setting boundaries, establishing trust, and achieving intimacy, are brought up to be worked on.

Low self-esteem is a primary symptom of physical and sexual abuse. It may be the most important symptom and one that makes it definitely necessary to look for other clues. All school personnel need to understand that most abused children tend to cope well in areas that ensure their survival. Some children who are being abused may appear to be well adjusted, happy children. They may also be "people pleasers" and they may be highly successful academically yet unable to maintain eye contact or be comfortable with interpersonal relationships.

It is essential that children be heard, have their feelings validated, and become empowered. This can occur in a variety of ways, and it takes time.

From Denial to Action

Social denial and, generally, denial by the families in which the abuse is occurring, foster abuse which promulgates rage. This feeds the cycle of developing additional perpetrators. We must stop this phenomenon. The average citizen is very unaware of the long-term devastation of sexual abuse. Statements such as "we don't need a program until we see abuse" were alarming.

School programs should be developmental, with follow-up activities for identified children, appropriate for their stages of healing. Curriculum content and support services should be age appropriate, appropriate for different learning styles and cultures, involve multi-sensory techniques, have adaptations for children with disabilities, and be culturally sensitive. The district's sexual abuse prevention and treatment program should be evaluated on a formative basis, a minimum of once per quarter or semester.

Efforts should be made to ensure that parents may not excuse their children from attending activities regarding sexual abuse prevention, unless it can be guaranteed

that equivalent activities are offered to the child. There must be an ongoing vigilance regarding siblings in a family where abuse has been reported.

The effects of sexual abuse prevention and treatment require the offering of services such as those listed on page 52-53. Programming must be comprehensive. The more frequently students understand what sexual abuse is, get the message that it is "not o.k.," and that they must report it and get help for themselves and for other children who could be affected, the more likely abuse is to be reported. Prevention and identification activities are not easily separated, in effective programs. Many children are not aware that they are being abused, and prevention activities can help them understand by defining abuse and stating children's rights. Prevention and identification activities should start at kindergarten age or preferably below. Prevention activities should include awareness of appropriate and inappropriate touch, protective behaviors, where and how to report abuse, appropriate peer referral, and empowerment skills. These skills should include dynamic portrayals (use of puppets has been found effective in many districts), of what is and is not acceptable touch and behavior. Children should be told that if the first adult that the child tells does not act on their behalf, they should tell another adult until they get assistance. Trust must be established between the child and school and community personnel, so that the "no talk" rule, preventing the disclosure of sexual abuse, can be broken.

Of course, the first step is to remove the children from dangerous situations. Their safety must be guaranteed, and they should be repeatedly told that they are in a safe setting and that they are with safe, responsible adults who are in charge. Peer support systems can be helpful when students are well trained and confidentiality is not an issue. Student assistance teams (school-based) teams are effective when confidentiality is maintained and when the persons involved are genuinely interested in the welfare of the students and are effective in dealing with them.

Prevention and identification activities should be integrated into on-going health and personal safety curriculum as well as drug and alcohol abuse activities, assemblies, general curriculum, and HIV/AIDS prevention activities. Most effective programs appear to address the issue through three to five days of programs per year and integration during the year across subject matter.

Empowerment skills should also include self-esteem development activities including an understanding that one has choices, can set boundaries, ways of effectively making decisions, how to accept consequences for actions, safety and refusal skills, substance abuse prevention, assertiveness, and resources available for reporting abuse and getting assistance.

Regarding follow-up services, they must be frequent, continuous, and involve open discussions in one-on-one situations or via small groups of children who have experienced similar situations.

Rapport must be developed between the students and teachers comfortable with the topic of sexual abuse and with children who have been abused. Children must

hear repeatedly that getting help is not only acceptable, but that they need and deserve it, to heal from sexual abuse.

One effective model of interagency collaboration is the Stuart House agency model in California in which agencies work together to conduct identification and follow-up services. This means that a child goes to one place as few times as possible for all reporting and court processes. This same building houses all services and everyone needed to investigate and prosecute a child sexual abuse case. This includes full-time social workers, prosecutors, and detectives on site; sensitive doctors skilled in performing the exams necessary to gather physical evidence without further traumatizing the child; specially trained law enforcement officers; child protection workers; social workers; and district attorneys. This facility was reported by Vanderbilt (1992) as a carefully coordinated process designed not to overwhelm the child. She reported that medical examinations were conducted slowly and were carefully adapted to each child's individual needs. The same social worker, prosecutor, and police officer work with the case all the way from intake to resolution. Children and family non-offenders receive free, long-term individual and family therapy. They see the investigators and social workers regularly. Children are prepared for the courtroom and are supported by a Stuart House staff member during their court appearance. The model is also described as cost effective as cases are well constructed and end in more guilty pleas (Vanderbilt, 1992).

Another effective model occurs with Catholic Community Services or similar agencies in conjunction with school activities. Children identified at young ages are given follow-up services as required, sometimes in off-campus group work, sometimes in individual work. They are followed throughout their career in school so that as issues arise regarding safety, self-esteem, trust and other relationship issues, they can receive assistance from a team that they have come to trust. Group work is especially valuable to teenagers who are becoming involved with the opposite sex and can discuss their concerns and progress with children of their own age who have had similar experiences.

The district's sexual abuse prevention and treatment programs should be evaluated on a formative basis, a minimum of once per quarter or semester.

Another technique favored by many districts is the use of case management teams. This strategy also requires that confidential information be kept confidential and that appropriate legal actions be taken. It stresses responsive and immediate intervention involving a variety of personnel within the school system and with affiliated agencies. It stresses that children must identify their feelings, have them validated, express them, and become empowered.

Student counseling should only be offered by those who understand the long-term healing process that is required in healing from child sexual abuse. Anyone who counsels the students and expects a quick or a one-time healing process will be frustrated. They may lower student self-esteem by conveying unrealistic expectations to students. Many districts make counseling options available through the district plus more extensive group and individual counseling by mental health personnel and/or private therapists. Therapists may come from health and human

service agencies, mental health centers, social services, and/or private practices. Interagency collaboration for effective follow-through is highly recommended, as long as the child's confidentiality is maintained.

Counseling must be responsive to emerging issues. For example, the child will first be concerned with survival and feel guilty about any impact on the family of the reporting of the abuse. They will have various layers of issues that will surface many times. The process must be understood from the point of view that the child must be guaranteed safety and deal with other survival issues. They must then focus on the layers of denial, guilt concerning the impact on the family and their perception that the abuse was their fault, rage, unworthiness, co-dependency issues, inability to trust, uncomfortableness with intimacy, setting and maintaining boundaries, and feelings of isolation. They must eventually become comfortable with putting their own needs first before taking care of others, and other feelings and issues will continue to resurface until the last layers of the onion have been peeled. School staff, children, and relevant family members need to understand the importance of valuing the child's healing as a process.

Developmental counseling is usually the preferred model, and must be responsive to emerging issues such as those mentioned above. It is helpful for children to be involved with support groups so that they understand that they are not alone, that they have rights to be angry, that the abuse was not their fault, and to see others who are also healing. Families may be encouraged to seek counseling. It is necessary for the sexual abuse survivor to have individualized counseling as opposed to only family therapy. The survivor has many personal issues to deal with, and a great number of those cannot be done effectively with other family members present. Family therapy, beyond that, may be helpful. Many schools have developed techniques using social workers in which children write their abusers and express their feelings about the abuse, children engage in creative activities for healing purposes such as art, music, expressive movement and dance, role plays, psychodrama, and stress management.

District and community personnel also need to be trained to understand that children do not report abuse if it did not happen. Sexual abuse involves too much shame for a child to talk about. The vast majority of children will not inflict this shame on themselves, unless they have a reason to do so. On the contrary, it is human nature to repress and deny abuse as long as possible, because of the shame and other stress it induces. Goodman (1990) conducted studies to test children's abilities to manufacture memories and the impact of authority figures and others to program children with leading questions and/or anatomically detailed dolls, to stimulate false accusations. Children were also tested under stressful circumstances, and they were re-interviewed after one year. Goodman found children's reports to be completely accurate, with not a single error in free recall made, even under stress, one year later. Goodman concluded that child abuse involves actions directed against the child's body. The violation of trivial expectations would probably not be very memorable. The violation of one's body is.

Regarding Teacher Education

Regarding teacher education, the key issues are attitudes, understanding, and resources available. Teachers have many requirements and priorities. Unless they understand the agony and the long-term effects of sexual abuse on children's self-esteem, that dysfunctional behavior patterns are learned for survival, and how emotional pain affects a child's learning potential, they may not understand the needs that the children will have.

Teachers need to be continuously supported. Most were not trained to deal with children who have been abused. In fact, only three states have minimal teacher certification requirements regarding training in child abuse. Most educators are quite concerned with how to fulfill their responsibilities to the children who have been abused and still teach the larger classroom. Many teachers are also uncomfortable because they have not dealt with their own sexual abuse issues, as people in our society are just now speaking out about this long-term problem. Teachers need to be trained regarding when to be involved with counselors and parents, what to expect regarding children's progress as they move through the developmental stages of healing, confidentiality issues, and when peer counseling may be effective.

Sexual abuse prevention and treatment must become a priority in teacher education. If one-third of the girls and one out of every four or five boys in a teacher's class have been sexually abused and are not capable of learning to their full potential, it is not realistic for a teacher to assume that he or she does not need to deal with the effects of sexual abuse. In addition, as mentioned earlier, sexual abuse has numerous ramifications for the classroom teacher including depression, low self-esteem, teen pregnancies, juvenile delinquency, "acting-out behavior, and anorexia-bulimia.

Learning to work with students who have been sexually abused will enhance teachers' abilities to work with all children. Teachers need to be taught how to observe sexually abused children in the class, exactly how to report the abuse to legal authorities, and that they have an obligation to do so. Some educators are being sued because they have reported to a principal or another school official and have assumed that the teacher's report will be reported to legal authorities. Teachers need to become aware of all school and community resources for healing sexual abuse. They need to understand dysfunctional family dynamics and behaviors common to perpetrators.

They need to develop sensitivity, listening, and communication skills; comfort with sexual abuse issues; processes of developing rapport with students, stressing open communication and the maintenance of confidentiality, in ways to assist with the child's healing, while carrying on their regular responsibilities. They need to understand the importance of non-judgmental responsiveness and follow-up, ways to assist children in feeling their feelings, methods of supporting children without ostracizing them as "different," and ways of working with families, when this is appropriate. Teachers need to understand that genuine caring and concern are essential and are much more crucial in dealing with a child who has been abused

than exactly what is said or done. Children who have been abused are very aware of the motivations for adult behavior. They are generally aware when an adult is sincere and when he or she is not. They tend to be more aware of others' feelings than of their own. Thus, what is said or done is frequently less important than having a warm, caring teacher who pays attention to what the student is experiencing and feeling.

Need for Community Education

Regarding community education, common issues are changing attitudes, building support, and services. The entire community must own the problem, become aware of its seriousness and how widespread it is and collaboratively design solutions. Nonjudgmental identification and services for families at risk should be in existence. Public service announcements and other techniques should be used in a high profile manner to make it clear that child sexual abuse will not be tolerated and that it has profound effects on individual children and on the community because of the social problems with which it is affiliated. Businesses can assist in spreading awareness of the problem and its effect on the community, and in designing and funding community solutions. Groups that might resist the program should be involved early in program planning so that their support will be gained.

Social Action Required

Social action must be comprehensive, thoughtful, and ongoing. Child sexual abuse, and related problems, have evolved over centuries, and they will not disappear overnight. Sexual abuse is typically a cyclical, generational family phenomenon. Perpetrators usually victimize numbers of children, and they victimize repetitively.

Social change is essential. Comprehensive, community-level approaches to empower families and to increase public awareness that abuse will not be tolerated and that offenders will be prosecuted, must occur. Children who are being abused need to be heard, made safe, have their feelings validated, and to become empowered. We must empower and support teachers so that they can empower and empathize with students. We must empower families that are at risk, so that their needs are met, and abuse does not occur.

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Appendix A

Survey Questionnaire

Name of District _____

Number of Students Attending _____

(**Interviewer ASK**: "What is your position in the district?")

RESPONDENT:

Superintendent	_____	Principal	_____
Assistant Sup't	_____	Dir. of Special Serv.	_____
Counselor	_____	Special Ed Director	_____
Teacher	_____	School Psychologist	_____

Other _____

Do you consider your district Rural _____ Urban _____
Suburban _____

INTERVIEWER: See our definitions below if you need to define Rural, Urban, and Suburban.

Rural: Number of inhabitants fewer than 150 per square mile, located in a county where 60% or more of the population lives in communities of 5,000 or fewer.

Urban: Towns or cities of more than 250,000 population.

Suburban: Residential communities generally located outside the city limits, but dependent upon the central city.

TELEPHONE SURVEY / WRITTEN QUESTIONNAIRE

Summer, 1991

My name is _____ and I am on staff with the National Rural Development Institute in Washington state. May I please speak with _____(sup't's name) or with the district person in charge of services for at-risk students?

Recent national studies indicate that at least 1/3 of all boys and girls have been sexually abused. Our office is attempting to determine <u>what preventive and treatment services are currently offered</u> by school districts across America. The results of the surveys will be anonymous, other than reporting <u>collective</u> data (for example, percentages of total respondents giving a certain response). The average time to answer the questions so far, has been from 10-15 minutes; and I'll be happy to send you a copy of the report.

1a. Is there a formal sexual abuse prevention and treatment program implemented in your district?

yes _____ no _____

1b. Is this mandated by your state? yes _____ no _____

2a. Which of the following topics are included in your staff inservice education program?

How to report sexual abuse _____
Confidentiality procedures _____
How to identify students abused _____
How to identify families at risk _____
Program planning with community involvement _____
Parental involvement techniques _____
School policy development _____
Student self-esteem resources _____
Academic assistance programs _____

2b. What procedures do you use to support your staff who experience difficulty when sexual abuse issues are discussed?

Refer staff to counseling services _____
Offer staff counseling _____
No procedures _____
Other (please describe) _____

3. **ASK THIS QUESTION IF THEY HAVE A SEXUAL ABUSE PROGRAM:**
As I read through the following list of groups, please estimate the percentage of each group that has received training in sexual abuse prevention and treatment curriculum.

	%
Administrative staff	_____
Special educators	_____
Teachers	_____
Other support personnel	_____
Community citizens	_____
Parents	_____
Students	_____

4a. **ASK THIS QUESTION IF THEY HAVE A SEXUAL ABUSE PROGRAM:**
Of the positions in the following list, which are involved, if at all, in program planning and implementation of your district's sexual abuse curriculum?

Superintendent _____ Principal _____
Teacher _____ Case Management Team _____
Counselor _____ Nurse _____
School Psychologist _____ Social Worker _____

Other (please identify) _____

4b **ASK THIS QUESTION IF THEY HAVE A SEXUAL ABUSE PROGRAM:**
Please estimate the amount of time that your district's prevention and treatment curriculum is offered.

Once per year _____ Once per semester _____
Once per month _____ Weekly _____
Integrated into ongoing school curriculum daily _____

4c. Is this amount of time <u>beyond</u> the state mandate?

Yes _____ No _____

4d. **ASK THIS QUESTION IF THEY HAVE A SEXUAL ABUSE PROGRAM:**
Do you feel your programs are <u>supported</u> or <u>tolerated</u> by your community?

supported _____ tolerated _____

4e **ASK THIS QUESTION IF THEY HAVE A SEXUAL ABUSE PROGRAM:**
How comfortable are the persons teaching the curriculum? (for example, answering difficult questions)

Very comfortable ___ Moderately comfortable ___ Not very comfortable ___

5. **ASK THIS QUESTION IF THEY HAVE A SEXUAL ABUSE PROGRAM:**
Does your district's sexual abuse prevention program focus on:

refusal skills _____
prevention _____
early identification _____
treatment _____
teacher training _____

6a. Is student attendance compulsory or may parents excuse their children from attending activities regarding sexual abuse?

Compulsory _____ Optional _____

6b. Please assess the effectiveness of your district's efforts relative to your district's objectives for preventing and treating sexual abuse?

excellent _____
above average _____
average _____
below average _____
poor _____

7. I'm going to read to you a list of possible components of your program. As I read this list, **please indicate** whether that component is included in <u>your</u> district's sexual abuse prevention and treatment program. **INTERVIEWER: Make sure their answer relates to components related to district sexual abuse prevention and treatment and <u>NOT</u> just a part of district services. (E.g., almost all districts <u>offer</u> counseling and vocational education to <u>all</u> kids.)**

Crisis counseling _____
Self-esteem enhancement _____
Education about feelings _____
Identification of feelings _____
Processing of feelings _____
Tutoring _____
Counseling _____
Vocational education _____
Social services _____
Family education/involvement _____
Planning committee of local community representatives _____
HIV/AIDS prevention _____
Community education _____
Strategies for empowering students _____
Communication skills _____
Recreational <u>alternatives</u> _____
Drama _____
Movement/dance _____
Art therapy _____
Music therapy _____
Comprehensive health services _____
Sex education _____
Drug and alcohol abuse education _____
English as a second language _____
Multi-cultural education _____
Peer support systems _____
Teacher support systems _____
Case management teams _____
Other _____ (Please describe) _____

_____

_____

8. Which of the following are actively involved with your district to encourage the prevention and treatment of sexual abuse?

Department of Child Protective Services or Department of Public Welfare _____
University teacher training programs _____
Community businesses _____
Law enforcement _____
Cooperative extension agency _____
Public health services _____
Foster care _____
Volunteer agencies _____
Private therapists _____
Substance abuse programs _____
Committee of community representatives _____
Other community resources _____

9. Of the positions in the following list, which are primary liaisons between the school district and community support services?

Superintendent _____
Assistant Superintendent _____
Principal _____
Teacher _____
Case Management Team _____
Counselor _____
Special Education Administrator _____
Psychologist _____
Nurse _____

10. How often is your district's sexual abuse prevention and treatment program evaluated?

Less than once/year _____
Once/year _____
Once/semester or quarter _____
NOT evaluated _____

11. Please tell me the most effective strategy your district uses to assist students at risk for sexual abuse or students identified as having been abused.

_____

_____

_____

_____

_____

Will you please send us a copy of your local sexual abuse procedures documents? (If such documents exist.)

Our address is:
National Rural Development Institute, Western Washington University, Bellingham, WA 98225

We will be glad to send you a copy of the Executive Summary of the report.

(If they want this, FILL OUT THE ADDRESS FORM ON FOLLOWING PAGE.)

THANK YOU FOR YOUR HELP!

* *

Interviewer's initials _____ Date _____

MAIL A COPY OF THE **EXECUTIVE SUMMARY** OF THE **1991 ABUSE SURVEY TO:**

_____

_____

_____

_____

_____

date mailed _____ initials _____